UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF MISSISSIPPI
OXFORD DIVISION

KELLI DENISE GOODE, Individually, and also as the Personal Representative of Troy Charlton Goode, Deceased, and as Mother, Natural Guardian and as Next Friend of R.G., a Minor, and also on behalf of all similarly situated persons,

Plaintiffs,

vs. No. 3:17CV60-DMB-RP

THE CITY OF SOUTHAVEN, TODD BAGGETT, Individually, JEREMY BOND, Individually, TYLER PRICE, Individually, JOEL RICH, Individually, JASON SCALLORN, Individually, STACIE J. GRAHAM a/k/a WITTE, Individually, MIKE MUELLER, Individually, WILLIAM PAINTER, JR., Individually, BRUCE K. SEBRING, Individually, JOSEPH SPENCE, Individually, RICHARD A. WEATHERFORD, Individually, JOHN DOES 1-10, BAPTIST MEMORIAL HOSPITAL-DESOTO, a Mississippi Corporation, SOUTHEASTERN EMERGENCY PHYSICIANS, LLC., a Tennessee Corporation, and LEMUEL DONJA OLIVER, M.D.,

Defendants.

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DEPOSITION OF ROBERT C. KRAUSE, EMT

DATE: October 11, 2017 at 9:40 a.m.

PLACE: Collins Reporting Service, Inc.
615 Adams Street
Toledo, Ohio 43604

REPORTER: Maureen Powers, RPR
Notary Public

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APPEARANCES:

On behalf of the Plaintiffs:

BALLIN, BALLIN & FISHMAN, P.C.:
Kevin M. McCormack
200 Jefferson Avenue, Suite 1250
Memphis, Tennessee 38103
(901) 525-6278

EASTLAND & GARRETT, PLLC:
James F. Garrett (via telephone)
103 N. Lamar Blvd., Suite 204
Oxford, Mississippi 38655
(662) 234-0804

On behalf of the Defendants the City of Southaven, Todd Baggett, Jeremy Bond, Tyler Price, Joel Rich, Jason Scallorn, Stacie J. Graham, Mike Mueller, William Painter, Jr., Bruce K. Sebring, Joseph Spence and Richard A. Weatherford:

MITCHELL, McNUTT & SAMS, P.A.:
L. Bradley Dillard, Sr.
Post Office Box 7120
Tupelo, Mississippi 38802
(662) 842-3871

On behalf of the Defendant Lemuel Donja Oliver, M.D.:

GASS WEBER MULLINS, LLC:
J. Ric Gass (via Skype)
241 North Broadway, Suite 300
Milwaukee, Wisconsin 53202
(414) 223-3300

RAINEY, KIZER, REVIERE & BELL, P.L.C.:
Amanda Waddell (via telephone)
Raymond James Tower
50 N. Front Street, Suite 610
Memphis, Tennessee 38103
(901) 333-8101

APPEARANCES (Continued)

On behalf of the Defendant Baptist Memorial Hospital - Desoto:

UPCHURCH & UPCHURCH, P.A.:
John Mark McIntosh (via telephone)
141 S. Commerce Street
Tupelo, Mississippi 38804
(662) 260-6953

On behalf of the Defendant Southeastern Emergency Physicians, LLC:

McDONALD KUHN:
Matthew R. Macaw (via telephone)
5400 Poplar Avenue, Suite 330
Memphis, Tennessee 38119
(901) 526-0606

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I N D E X

EXAMINATION

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EXHIBITS

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(Court Reporter marked Exhibit Numbers 1 - 10.)

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MR. DILLARD: We have premarked a number of exhibits, I'm going to go back through these to be sure we're all clear on what they are.

Exhibit 1, notice of deposition. Exhibit 2 would be the resume and, description of Leading Technologies, LLC and resume of Mr. Krause. Exhibit 3, list of case testimony over the last four years. Exhibit 4, Mr. Krause's July 31, 2017 report. Exhibit 5, portions of a publication, Emergency Care and Transportation of the Sick and Injured, Tenth Edition. Exhibit 6, excerpts from an American Heart Association Provider Manual article, Advanced Cardiovascular Life Support. Exhibit 7, excerpts from publication EMT Prehospital Care, Fourth Edition. Exhibit 8, the Southaven EMT patient care record and run report. Exhibit 9 would be another copy, I believe,

of Mr. Krause's testimony list along with CV. Exhibit 10, portions of an article, Essentials of Paramedic Care, Second Edition.

I'd like to go ahead and make those exhibits to the deposition at this time. Having heard no objection, swear him in.

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ROBERT C. KRAUSE, EMT,

a Witness herein, being first duly sworn to tell the truth, the whole truth, and nothing but the truth, testified and said as follows:

EXAMINATION

BY MR. DILLARD:

Q. Could you state your full name, sir?

A. Robert C. Krause, K-r-a-u-s-e.

Q. Mr. Krause, my name is Brad Dillard, we met just a few moments ago. I'm one of the attorneys representing the City of Southaven, defendants, the City of Southaven, a number of police officers, and then EMT Stacie Graham.

I'm here today to ask you some questions about a report that you submitted to the plaintiff's counsel dated July 31, 2017.

If at any time I ask you a question that is not clear or if you don't understand me, would you agree to stop me, let me know so that I can repeat that or rephrase it for you?

A. Yes, sir.

Q. And having seen your case list, you obviously have testified either in a deposition or trial a number of times, correct?

A. Yes, sir.

Q. You're familiar with the process?

A. Yes, sir.

Q. If we can just have an agreement then that if you'll let me finish my question, I'll do my best to let you finish your answer, and then our nice court reporter won't be mad at either one of us.

A. Yes, sir.

Q. Would you just give me the benefit of your educational background and your work history?

A. Yes, sir. Do you want my full educational background or do you want academic degrees, training?

Q. Academic degrees, training, then sort of bring me up through your work history.

A. Okay. In the academic degree area, I have an Associate's degree in fire science, I have a Bachelor's degree from the University of Cincinnati in fire and safety engineering. I have a Master's degree from Bellevue University in security management, which is homeland security types of issues, and I'm currently completing my Doctorate in organizational leadership at Bowling Green State University.

I've been a certified paramedic since 1981. I have maintained that licensure the entire time without interruption. My training includes, may I look at that CV, and I'll just, I'll itemize this for you.

Q. I'm going to hand those to you.

A. Thank you. Academic-wise, and I can put all of this on the record if you want me to, all of these on there.

Q. No, no. We can look at that. I just want sort of a broad overview of your work history and your educational background.

A. That's my educational background in paramedicine. I'm an EMS instructor, I teach EMT programs in the state of Ohio. I'm also a fire

instructor, I teach firefighting techniques as well in the state, throughout the United States and Canada.

I have been working in the field since 1981, since 1993 I've been here in Toledo. My current position is battalion chief with the City of Toledo.

Q. Do you still serve actively as an EMT?

A. Oh, yes, sir. I'm an active supervisor. I'm on the line, I respond to incidents. I'm very active in my battalion.

Q. In your battalion, your fire battalion?

A. That's how it's called, it's a geographic area. There's three battalions in the city. Mine is the center city and east side and some of the north end, but it's the geographical area that I supervise, there are 18 fire stations in the city, six of which fall under my battalion, and I respond routinely with those crews throughout the battalion to a variety of incidents.

Q. Okay. Those don't involve transportation of patients with an ambulance?

A. They do. Absolutely.

Q. You're personally involved in

transporting patients in an ambulance?

A. Well, it depends on the case, but most of the time I do not get in the back of the ambulance. I mean, I'm at the scene and we have medic units there which transport the patients. But I am there as they're being put in or taken out as the scene unfolds, I'm involved.

Q. With your battalion, then, are you typically responding to a fire or some other type of emergency like that?

A. Well, I have some administrative duties which deal with staffing, potentially discipline, but my focus on a daily basis is operational things that are occurring within my battalion, which is responding to fires, car accidents, medical emergencies, drug overdoses, shootings, those types of incidents.

Q. I'm just trying to be sure I understand your current position then. You would oversee the firemen who are on the scene as part of your job duties?

A. Yes, sir.

Q. And then would you separately have EMTs who would respond, say, to an auto accident with an

ambulance?

A. Yes. But they are all within the fire division. We're all in the same organization. So your example of an accident, we will arrive with Toledo firefighters on a fire engine, or two, depending on the significance of the incident, and also the Lucas County paramedic units contain Toledo firefighters, as well as the Toledo medic units, which are BLS rigs, if push came to shove, could operate on an advanced level. Those are all filled with Toledo firefighters.

Q. So if you respond to our hypothetical car accident, you're there with the firemen and also the EMTs are on the scene, are you over the EMTs and the firemen and you're dictating what happens at the scene?

A. Yes, sir.

Q. When is the last occasion you would have personally been involved in transporting the patient where you got in the back of the ambulance and went with him to the hospital?

A. It would have to be within the last year. Most of the time we'll put more than enough people in the back of the ambulance to make sure,

and I would say, boy, even closer than that because we had an obstetrical incident that required a lot of attention within the last five months in which I was in the ambulance.

Q. Just, say, in the last year then, because you mentioned that time period, in the last year, how many occasions would you have had to actually be in the back of an ambulance with a patient during transportation to a hospital?

A. No more than two.

Q. Now, the documents you looked at that you have in front of you as part of Exhibit 9, is that your personal resume?

A. Yes. The conference at the very top didn't happen in 2917. It's a little bit too much in the future, but it was in 2017. But the Clare Firefighters Association was 2017. That's the most current, yes.

Q. Thank you.

A. You're welcome.

Q. This resume then would list all of your education, training, work history, certificates, licenses, everything pertinent to your professional operation, correct?

A. Yes, sir.
Q. Then the separate document that we have marked as Exhibit 2 references Leading Technologies, LLC?
A. Yes, sir.
Q. How is that document different from your personal CV we just talked about?
A. Well, this is not something I generated. This document is generated by the company Leading Technologies. That's not me. I would imagine that they, at some point early on, cut and pasted this to put it into their website. I don't oversee that.
And I'm sure, just by looking here, they changed the format a little bit. But in basics, this is a summation of information. But this is something that they generate and I have no control over.
Q. Who is or what is Leading Technologies, LLC?
A. This is run by a gentleman named Bob Yano, Y-a-n-o, and he is a, well, clearinghouse. He has experts that, when attorneys need an expert in a certain area, they call him, he researches his database, if there's someone applicable, and then

provides that information to the attorneys.
Q. Would you be one of the experts then that would be in the Leading Technologies database?
A. Yes, sir.
Q. Is that a service that you have to pay for?
A. No, sir.
Q. How is Leading Technologies compensated if you're retained in a case?
A. I believe the attorneys pay him. I'm not familiar with that financial arrangement. It doesn't involve me.
Q. When you're retained through Leading Technologies, do you personally execute a contract or have a direct agreement with the attorney retaining you?
A. No, sir. It goes right through Yano and Leading.
Q. So your billing would go to Leading Technologies who would then bill the attorney hiring you?
A. Yes, sir.
Q. And the document itself, again, I believe you said, is sort of a summation of the

other document that we looked at, your resume, correct?

A. Yes. I don't know how complete he is or if he makes any edits to it. That information is not available to me.

Q. How long have you been affiliated with Leading Technologies, LLC?

A. I think I've helped Bob over the last couple of years, two years, three years maybe.

Q. Do you know Bob on a personal basis?

A. I wouldn't know him if he walked in this room, sir.

Q. How did you come to be affiliated with this company?

A. He called me. I would imagine early on he was mining for experts, and asked if I would be interested in being in his group, I said, sure.

Q. No cost to you?

A. No cost to me.

Q. Do you advertise for your services anywhere else, or are you affiliated with any other companies like Leading Technologies?

A. Not that I'm aware of. I used to advertise, but I just, I don't anymore. There is no

need to.

Q. Do you have any type of company that you set up that you perform your expert services through?

A. Yes.

Q. What is that?

A. The name of the company is Emergency Services Consultants.

Q. Is that a corporation?

A. Ltd., yes, sir.

Q. Formed under the laws of the State of Ohio?

A. State of Ohio, yes, sir.

Q. When did you form this company?

A. Geez, that's got to be within the last 10 years. I'd have to go look at the certificate on the wall, but within the last 10 years.

Q. Was that strictly for your expert work?

A. Yes. And, well, it was, it started out as teaching, I was doing more teaching than I was doing anything else. And then there happened to be an attorney in one of the classrooms that I was doing some teaching for, and he asked me if I knew what an expert was. I had a basic idea, yeah,

you're good at what you do, but I didn't know the witness thing. And he retained me in a case, he asked me for some things, I gave them to him and he said, this is what this is.

Q. Does Emergency Services Consulting have any other employees?

A. On occasion, one.

Q. Who would that be?

A. My wife. She's a law enforcement expert. She's a police captain for the last 34 years. She handles law enforcement issues, a variety of things.

Q. So she'll act as an expert witness in those areas?

A. Yes, if she's asked.

Q. As far as a percentage basis of your total annual income, how much of that would be generated through your expert work versus your work as a battalion leader or other services you might provide?

A. About 20 percent.

Q. Has that been consistent over the last three to four, five years?

A. Yes, sir.

Q. How much time on average would you spend in a given month performing expert work such as this, giving a deposition, reviewing material, generating reports, things like that?

A. Well, it certainly depends on the caseload, but you're asking number of hours?

Q. Just on average on a monthly basis.

A. Maybe 30 hours maybe. There have been months where it's been a little higher, but certainly months where it's been lower.

Q. Has your, any certification or licensure you've had for basically EMT-related services ever been suspended or revoked, modified, any sort of limitations like that placed on it?

A. No, sir.

Q. Ever been subject to discipline by your governing body?

A. No, sir.

Q. Who would be the governing body in Ohio that would monitor EMTs?

A. It would be the State of Ohio, Department of Public Safety, the EMS Bureau.

Q. Does that EMS Bureau, do they have their own set of protocols and guidelines for EMTs?

A. To function under, as in medical protocols?
Q. Yes.
A. No, sir.
Q. The reason I'm asking, in your report, we'll get there in a moment, you referenced some protocols in Mississippi.
A. Yes, sir.
Q. I want to know if Ohio has similar protocols to those.
A. Most of the jurisdictions all have their own, I don't know of a blanket Ohio protocol that says, this is what you'll do. I've functioned under the Lucas County protocols for the last 26 years, so I'm not aware of any blanket Ohio protocols.
Q. Have you ever been licensed as an EMT in any state other than Ohio?
A. Yes.
Q. What would those be?
A. Michigan. Pennsylvania.
Q. Are those still active certifications?
A. No, sir.
Q. When did those lapse?
A. Well, Michigan was probably the late

'80s, because I just simply didn't want work there, and Philadelphia, well, Pennsylvania would have lapsed in, maybe the very first part of 1990, 1991, somewhere in there, after I left Philadelphia.

Q. You allowed those to lapse voluntarily?

A. Yes, sir.

Q. Going back to the protocols for a moment, prior to becoming involved in this case, had you ever had an occasion to review any protocols for EMTs in the state of Mississippi?

A. No, sir.

Q. Do the Lucas County protocols that you operate under, are they similar to or different from the Mississippi protocols you reviewed for this case?

A. Similar.

Q. Is there a national or standardized set of protocols for EMTs?

A. Well, there's a standard of care, and the standard of care is generated by the educational materials, the governing bodies such as the American Heart Association. Certainly medical practices that are throughout the country have become standardized. There's a standardized curriculum, which is the

Department of Transportation emergency medical technician paramedic curriculum, and that means that the paramedics in Boston, Massachusetts are being trained the very same way they are in San Diego, California. So it is the national standard.

What is then typical is localities develop and base their own protocols off of the national standards. For example, in California, each county has some very slight differences in their protocols, but they, at least, all meet the minimum.

So, you know, County A might have a little bit more than County B, but they all hit the very minimum of the standard of care.

Q. What is the minimum of the standard of care? How is that established?

A. Well, it's established by that standard of care that I mentioned, by the current texts that are out there, by the research that is being done, by the States who say that we would adhere to these types of standards and use these methods for our protocol development.

Q. Would you agree that essentially the standard of care is what a reasonably prudent EMT

would do under the same or similar circumstances?

A. Well, that's close, but there has to be what is the basic standards. Now, for Mississippi, they've established that, these are what the paramedics shall function within. They've made it very clear in their opening parts of the document.

So they've made it clear that if you're working in the Mississippi, you'll function under these guidelines.

Q. And is it your position that the Mississippi guidelines give no discretion to deviate from any of the protocols at all under any circumstances?

A. Well, discretion is, this is the guidelines that they have set. Now, they also talk about if you have to switch protocols, you may have to do that. In other words, if I start treating you for chest pain, but then as I begin to evaluate you and develop my differential diagnosis, I also determine you have COPD. Then I'm allowed to start blending some of those, and which I have to then document why I did it. There's very little discretion, I mean, these are what you're being told to do.

Q. Well, the protocols, I'm kind of using your example, you're treating the patient, you recognize there may be a different problem that exists, would it be important then for the EMT to be able to put eyes on the patient, to assess the patient, to interact with the patient to make that determination as to what problem or scenario is developing?

A. Well, absolutely. I mean, you can't make a diagnosis, we couldn't, as you and I sit in this room today, we couldn't make a diagnosis on a patient who's back in the kitchen. I mean, we have to have eyes on the patient, we have to be able to interact with the patient at some level, and then make decisions on what we see, what our vital signs tell us, or don't tell us, then respond appropriately within our protocols to manage that patient.

Q. So the EMTs' implementation of the protocols you talked about would be in large part based on their assessment of the scene, assessment of the patient, and just an overall determination of what the appropriate care would be?

A. Yes.

Q. I'm going to look at your list of testimony, do you have a copy of that?

A. No, sir, I don't.

Q. Let me hand you one that's been marked, actually I think we have two copies that are marked. I want to be sure they're the same.

A. Yes, sir.

Q. The first one is Exhibit 3, that's a copy we were provided along with your report. Then there's another copy that is marked as part of Exhibit 9.

A. Yes, sir. I sent multiple, I wanted to make sure that these were available to you, so I sent them here to the reporting agency so that we had these, that we weren't, where the hell are they, kind of thing.

Q. Are those two the same document or any changes to the one you sent?

A. These are the same. There's 3, or one in 9, whatever.

Q. Exhibit 3 and Exhibit 9, are they both same document?

A. Yes, sir.

Q. They would list all of your depositions

or trial testimony over the last four-year period?

A. Yes, sir.

Q. Have you ever testified in the state of Mississippi?

A. No, sir.

Q. Has any court, to your knowledge, ever disqualified you as an expert for any reason?

A. Absolutely not. No, sir.

Q. Are you aware of any, what's called a Daubert challenge?

A. Yes, sir.

Q. Have you ever been challenged on that basis, either due to your qualifications or the content of your opinions?

A. Yes, sir.

Q. And which case of these cases, which did that happen in?

A. This happened in the Miami case, let's see, they tried to Daubert me out during trial, they actually asked for -- here it is right here. Elisa Chovel versus the City of Miami, 11th Judicial Circuit in Miami, Dade County, Florida. There's the case number. The patient had had a stroke, so they --

Q. That's the second case on the top of Page 2?

A. Yes, sir.

Q. Okay.

A. Defense counsel wanted to have a challenge right in court. The jury was dismissed, I was put through the process and the judge said, there's absolutely no way Mr. Krause is not qualified to opine in this case.

Q. That's the only case you're aware of where you faced a Daubert challenge?

A. Well, to my face. I mean, there were certainly some other cases, I can't recall which ones they were, that tried to Daubert me out. They were very unsuccessful.

Q. Right. That being the only case you actually had to testify in court as to your qualifications?

A. Yes, sir.

Q. Have any of the cases where you've testified involved a factual situation that is similar to the facts in this case, where a patient took LSD or some other illegal drug, was restrained by police, transported via ambulance to a hospital,

and subsequently expired?
A. No, sir.
Q. Have you had other cases that you have reviewed and either given an opinion or not that involved a similar set of facts?
A. No, sir.
Q. Okay. I'm going to go into your report, let's make sure you have a copy of that in front of you to refer to.
A. I do, sir. I think. Well, I thought I had one.
Q. I have one if you don't.
A. Right here, sir. I do.
Q. I'm going to get into that, but first of all, let me just be sure. Am I correct that the opinions you're giving in this case would only be focused on EMT Stacie Graham?
A. Yes, sir.
Q. You're offering no criticism of, say, the Southaven Police Department?
A. No, sir.
Q. You're offering no criticism of any Baptist Hospital personnel who worked in the ER department, nurses or other staff, correct?

A. No, sir.
Q. You're offering no criticism of Dr. Oliver, the ER physician?
A. No, sir.
Q. Just so we get a context of the EMT services we're talking about, there's a document that we've premarked, that would be the run record?
A. Yes, sir.
Q. I hand you that to you. That's Exhibit 6. I think on the top right-hand corner it has the various times where the EMT responded, is that correct?
A. Yes, sir.
Q. Would you go through those from the first call until the EMT was totally off the scene?
A. The call was received at 19:55:11, do you want them all enumerated?
Q. Yes, if you would.
A. They were dispatched at 19:55:11. They were en route at 19:55:12. They were on the scene at 20:01:13. They were at the patient at 20:02:19. They depart the scene at 20:14:44.
Q. Let me stop you there just a second. So between arriving at the scene and getting to the

patient then, I may have misunderstood you. Those last two you referenced, one was arriving on the scene?

A. Yes, sir.

Q. What was the next one you referenced?

A. At patient.

Q. What time was that?

A. 20:02:19.

Q. So then from the time at patient until they departed the scene, how long was that?

A. It's about 12 minutes.

Q. Is that excessive or normal, in your opinion, or do you have an opinion about that?

A. No, that's a good time. That's a reasonable time. Mr. Goode is already restrained at that point and they're not doing a lot. I mean, they put him on the cot, they start moving toward the ambulance. It's a reasonable time.

Q. So during that time period from when they arrive on the scene until he's placed in the ambulance, do you have any real criticism of Ms. Graham, just during that limited time period?

A. By the time --

Q. Between arriving on the scene and

putting their hands on Mr. Goode and placing him in the ambulance?

A. Yes.

Q. So I know there's a separate time period we're talking about that's the actual ambulance ride to Baptist. I'm just going to segment those out.

If we're critical of Ms. Graham during this initial time period that we just talked about, what would those specific criticisms be?

A. The specific criticism, from the time she arrives until Mr. Goode is being placed in the back of the ambulance is leaving him prone. There is absolutely no support for leaving Mr. Goode in the prone position.

The literature is full of references not to leave them in that position. The protocols are very clear that Mr. Goode should not be left in that position.

So from the time she makes contact with him until he's placed in the back of the ambulance, she had an opportunity to intervene. She did not.

Q. Okay. So during that limited time period we're talking about, before he's placed in the ambulance, that would be your criticism, leaving

him in the prone position?
A. Yes, sir. And it's not a limited time. Remember, all we're suggesting, all I'm saying is that all she had to do was move him 90 degrees. All she had to do was get him off his stomach. And I have had cases myself in which that interaction alone can happen within seconds.
Q. Again, what I'm just trying to do is make sure, because I want to get into all your criticism, I want to make sure we cover them all.
A. Yes, sir.
Q. During this initial time period right before he's placed into the ambulance, okay, your only criticism at that point would be the leaving him in the prone position as opposed to turning him on his side?
A. Well, but that's a very significant criticism.
Q. I'm not saying it's not, I'm just saying that is your criticism during this time period?
A. In that short, brief time period.
Q. That 12 minutes or so?
A. It's not 12 minutes. She's at his side at 20:02, then there's 12 minutes that they depart.

Q. Right.
A. So they're not, these times don't indicate what happened in the back of the ambulance.
Q. Okay.
A. So as soon as her hands are on at 20:02, she has the opportunity to start intervention, almost immediately. And in this initial phase, so he's in the back of the ambulance, all she would have had to do was get him on his side. Because I understand she needs to get him in a more controlled environment.
Q. Which would be the back of the ambulance?
A. Which is in the back of the ambulance.
Q. So he's placed in the back of the ambulance, at that point pick back up with the chronology, what's the time period before arrival at the hospital?
A. Well, the records say that she's at the patient at 20:02:19. They depart the scene at 20:14:44. So that time period is from when she puts her hands on him until they leave the scene.
So depending on where she is in the gap, and that's not enumerated here, how much time she's

in the back of the ambulance with him. From the time they depart the scene until they are at the destination, the destination is 20:26:59. So about 12 more minutes in the back of the ambulance.

Then it's not until 21:10 that the patient is transported or transferred over to hospital staff. So she has him, well, geez, almost 40 minutes under her care as opposed to what's on her record here.

Q. So the ambulance ride itself indicates, as indicated on the record, took about 12 minutes to get from the scene to Baptist Hospital?

A. Yes. They departed 20:14:44, and it says arrived at, or at destination at 20:26:59, about 12 minutes.

Q. Have you looked at any of the hospital records to determine when the hospital took over care of Mr. Goode?

A. Yes.

Q. When is that?

A. I don't have that in front of me, but I would have to look at the BHS documents and I could research them for, if you would like me to, but I don't have the exact time, no.

Q. Just in your experience as an EMT in transporting individuals to a hospital, to an ER, at what point do you typically perceive that you have tendered the patient over to the ER staff for care?

A. Let me just go back to a record. It says here that the arrival is 20:28. It says here code vitals are at 20:33. So I would believe that that's when he's in the hospital, the 20:33 time frame, along there, but I don't have -- that's the best I have.

Q. That would be when the hospital staff took his vitals?

A. Yes, sir, when they began to assess him.

Q. Going back to my other question, would that be the point, or what would the point be in your experience when a patient is transferred out of EMT care into ER care?

A. Well, it can vary. The transfer period can actually vary, depending on how busy the ER is, what's the status of the patient that you bring them, do they have an available bed to put him in, what the staffing center at the hospital was, but typically the period could be anywhere from two to three minutes to 10 minutes or more and is

situational upon the receiving facility.

Q. As an EMT, you're not permitted to give actual patient care in the ER, are you?

A. Well, no, sir. I mean, you're certainly not going to stand idly by while the patient is in duress because you're in a facility. I have had opportunities on numerous occasions over 36 years to where interventions were, absolutely had to be done by me still in contact with that patient. In fact, my responsibility doesn't end when I cross the threshold of the emergency department. There hasn't been an official transfer of patient care.

So that person still belongs to me until there has been that exchange of information and acceptance by the emergency department personnel.

Q. Would that typically be at the triage point?

A. The triage point could be one spot, but depending on again, sir, patients, sometimes we don't stand in the triage bay because we're going to get them into a particular room to hand them.

Q. Do you have an opinion in this particular case when Ms. Graham would have handed off care to the Baptist personnel?

A. There's nothing clear and definitive. I mean, they go into the emergency department, the emergency department takes over. I mean, the only thing I can go to is her own statement when she says she transferred care at 21:10. I mean, that's the record she put in.

Q. Okay. But we also have the record you referred to a moment ago where vitals were taken at 20:33?

A. Yes, sir.

Q. Have you reviewed the deposition testimony of the nursing staff at Baptist?

A. Yes.

Q. Didn't that deposition testimony indicate that care was taken over much earlier than the time frame Ms. Graham referenced in that run report?

A. Yes.

Q. Would you agree that once a patient is accepted in the ER department as a patient, at that point the EMT's responsibility to provide care does, in fact, end?

A. Well, I think it ends to a point. But if there's mismanagement of the patient, then it

shouldn't end. I mean, you know, Mr. Goode is still on his belly, which as you know, I'll argue he shouldn't have been, but typically what happens, my experience has been emergency departments tend to follow the path of the EMS crew that brings him in. I mean, they will make deviations based on their recognition and assessment. But my experience has showed me that if I say that this patient is a seizure patient, or a chest pain patient, they'll typically follow that lead until they make another determination.

I mean, they are relying upon the EMS crews to lay the groundwork for them in how they initially approach the patient, then they can diverge from that, however they see fit.

Q. So the EMT will provide the initial information to the ER department about the situation with the patient or the problem the patient is experiencing, would that be accurate?

A. Yes, sir.

Q. But then the ER department, through its nursing staff and its physicians, will determine whether the existing course of treatment is the best course or something else should be tried?

A. Yes, sir.
Q. Or implemented. You would recognize, I guess, and acknowledge that an ER is a higher level of care for a patient than an ambulance an EMT?
A. Yes, sir. That's why we take them there.
Q. Absolutely. That's why Mr. Goode was taken to the ER department that night?
A. Yes.
Q. For higher level of care?
A. Yes, sir.
Q. Would you agree that Mr. Goode's complaint or his problem that night was, in fact, an LSD overdose?
MR. McCORMACK: Object to the form.
A. That was the initial problem. That was the initial then, but then all the physiological things that happened trailing that are what the EMS personnel can intervene on and correct. I mean, that was the initial stimulus.
But the resulting physiological conditions are what we can change.
Q. The EMTs responded to the situation with a patient who they believed had overdosed on illegal

drugs, correct?

A. Yes, sir. I've done that routinely.

Q. That was the situation that they expected to address when they arrived at the scene?

A. Yes, sir.

Q. I want to look at your report, July 31, 2017 report. Have you provided any supplemental reports or additional reports since this report?

A. No, sir.

Q. There's a list of materials that you indicate you had reviewed, being documents 1 through 18?

A. Yes, sir.

Q. It includes deposition testimony and some other material. Have you reviewed any additional material other than what is set forth in your report?

A. No, sir.

Q. So since you generated the report, you have not been provided any additional depositions of experts or anything like that?

A. No, sir.

Q. Have you reviewed any of the expert designations of any of the defendants in this case?

A. No, sir.

Q. Did you have any conversations or other communications with plaintiff's counsel prior to generating the July 31 report?

A. No, sir, not that I can think of.

Q. Explain the process then with the Leading Technologies, that you'll generate a report. Do you send the report directly to, in this case, Mr. Edwards, or does it go through Leading Technologies?

A. No. Once Leading Technologies makes the connection, Leading Technologies, on my end, has no further intervention. I have dealt strictly with Mr. Edwards or Mr. McCormack.

Q. So Mr. Edwards or Mr. McCormack would have sent you the material that you've listed in your report, numbers 1 through 18?

A. Well, they certainly would not have sent me the reference materials, sir, the 13, 14, 15, 16, 17 and 18 was not sent to me. Nor was 12. I found 12 on my own as well. So 12 through 18 were my own research and development.

Q. So counsel did not send you any type of articles, texts or any other publications?

A. No, sir. I found them myself.
Q. Okay. You simply were provided the deposition testimony, EMS patient care report, the policies and procedures, dispatch information, and any other things, as you said, numbers 1 through 11?
A. Yes, sir.
Q. And in finding that video that's listed as number 12, were you just Googling what had happened at the scene?
A. Yes, sir. I was looking for anything that would reference what happened in this scenario that popped up.
Q. Have you asked to review any additional material in this case such as the deposition of Ms. Goode or any of Mr. Goode's friends?
A. No, sir.
Q. On Page 1 of your report, it states that you have extensive experience transporting patients, including patients that are violent, screaming and threatening. Also experienced transporting patients in police custody. Just briefly tell me about your experience with those types of patients.
A. Okay. This spans the gamut of 36 years, but certainly I've been in incidents where drug

overdose patients are violent, screaming, they're coming unglued. I've been in instances where patients have been shot or have been injured, and at the same time were also in police custody.

I have personally been on scene where at initial arrival the patient is in the prone position in a hog-tie fashion where we've gotten him over on his side immediately. I've had, I was in the back of a rig where a gentleman tried to rob a hotel poker game, and in his attempt to rob the poker game, shot a police officer. He then, in turn, was shot, fractured his femur, he's in the back of the ambulance with several police officers in police custody, managing these patients. We are trained to deal with these types of patients. It's not something unusual.

Q. You've been involved with patients who have been threatening or potentially violent?

A. Oh, yes, sir.

Q. And, again, you've had cases where police officers were required to be in the back of the ambulance with you to maintain custody over the patient, also to protect the EMTs, correct?

A. Well, not so much protection, but, I

mean, their presence was like a big watchdog on a porch. I mean, they were there if we needed their help, they would help us, but they weren't there to protect us, they were there to maintain the integrity of the custody.

Q. Have you ever had a situation where you felt physically threatened by a patient?

A. Me?

Q. Yes, sir.

A. No, sir.

Q. You're a fairly large guy, though, correct?

A. Yes, sir.

Q. Do you have any knowledge about Ms. Graham, how large she is or her experience dealing with patients like Mr. Goode?

A. Well, she's not a big person. But what she did have to her advantage in the back of that ambulance were two of those watchdogs that I referenced earlier.

So had she been, in my opinion, under any threat, all she would have had to do was ask the officers to help intervene, and then it is my guess they would have helped her.

Q. I'm going to go to Page 3 of your report.

A. Yes, sir.

Q. You sort of go through a summary of what occurred with Mr. Goode, that he was at a concert, that he ingested some drops of LSD, his reaction was that of having a bad trip. Where did you obtain this factual background information, from the depositions or from some summary provided by counsel?

A. No, this was, the initial part was on a discussion of the case, that this is how he had gotten in that scenario, that he was having a bad trip, and as I started reading the depositions, you can tell from Ms. Graham that this guy is having some problems, and that she's basically aware of a drug overdose. And so those are my words in a summation of what is happening.

Q. You said an initial conversation, an initial conversation with whom?

A. Mr. Edwards.

Q. And how long did your initial conversation with Mr. Edwards last, approximately?

A. Boy, half an hour.

Q. Do you recall, other than this factual summary, what the two of you discussed about the case?

A. No, sir. It was early July, I was on an island, I don't recall.

Q. Was this conversation memorialized in a follow-up e-mail or letter?

A. No, sir.

Q. But it gave you some sense as to the factual background of the case?

A. Yes, sir.

Q. What had occurred? Now, there's a statement, police were called to the scene, after some time Mr. Goode was tased by one of the police officers.

In the deposition testimony you reviewed, does it indicate to you that Mr. Goode was, in fact, not tased, but rather there was an attempt to tase him?

A. Well, the fire happened, I don't know if both bars made target, I don't know if they made contact. But that whole evolution of process is that, you know, the process was attempted. Whether both bars hit him, I don't know that.

Q. Both bars do have to hit the individual before there's electric shock, correct?

A. That's my understanding, yes, sir.

Q. Are you aware of any testimony then that indicates Mr. Goode was, in fact, not tased or not shocked at the scene?

A. I don't know of anything that says that, no, sir.

Q. In regard to the statement that he was, in fact, tased, what would you base that on?

A. The fact that the weapon was discharged. There is no indication to me that I have been able to find at this point that clearly says it was a hit or not.

Q. So you're just basing that on the fact that it was, in fact, discharged?

A. It was discharged. Whether it hit him or not, that's the law enforcement types of, of the incident that I did not opine upon. The accuracy of that officer with his taser is not in my purview.

Q. You state that Mr. Goode's behavior was erratic. What is your understanding of exactly what Mr. Goode's behavior was at the scene at the time, at or around the time the police officers arrived?

A. Well, by this time, he was experiencing hallucinations, he was hollering, he was running around. If you were to see him, people would definitely pay attention to him and his behavior, that he's running around, he's non-compliant. He is certainly not orderly.

Q. You believe at that point he posed a danger to himself and to potentially others?

A. Yes, sir. Certainly to himself. I don't know about his threat to others. He's a guy who's 6 foot tall, maybe 150, 60 pounds. He's not a strapping lad. But he certainly could have been a danger to himself.

Q. If someone runs out in traffic on a busy street, that poses a danger to others as well, correct?

A. Yes, sir.

Q. Now, you have an image number one, that image is taken from the McLaughlin video?

A. No, sir. That's out of the newspaper. There's a newspaper article also where that image shows Mr. Goode being put in the back of the ambulance. It is also replicated in the video itself.

Q. Image two then is, you represent is the four-point restraint or hog-tied position, in that image number 2, the hands and feet are bound close and securely together, correct?

A. Yes, sir.

Q. Now, in this particular case, with the four-point restraint where there is a linked chain that allows for movement, do you still consider that to be a hog tie?

A. Unequivocally, yes, sir.

Q. You see no distinction between the image, image 2 and the chain and shackles used in this particular case with Mr. Goode?

A. This image 2 might have a little bit more closer proximity than image 1, but positionally it's the same thing.

Q. Positionally being up on the stock?

A. Yes, sir. And hands and feet behind him in a drawn-up position.

Q. Okay. Again, the fact that there is some 18 inches or so of flexibility to move, that makes no difference to you in your opinions?

A. Well, you say it's 18 inches, that's the length of a chain. If you cut it in half, it's 9

inches. Because it loops around the legs. So he has a 9-inch gap, he doesn't have 18. So the best he can do is basically get one leg a little bit straighter than the other, but he cannot, he is still bound in a hog-tied position.

Q. Again, that ability to move somewhat makes no distinction to you between that and the hog-tie position shown in image 2 where the hands and feet are securely together behind the back?

A. Well, as I said, the image number 2 is a representation of what image 1 is. Image 1 is a little bit grainy, we can't really define that. We'd need to have the original for that.

But basically that is the position that we're talking about, and that is hog-tied.

Q. Is image 2, is that an image that you found on the Internet just to sort of link to image 1 as sort of a representation?

A. Yes, sir. In fact, I even identify that, I say in the report, image 2 is a general representation of Mr. Goode's position prior to and during his transport in the ambulance.

Q. Right. I want to go over to Page 4.

A. Okay, sir.

Q. This is where you sort of go through the treatment that was provided to Mr. Goode. If you could, just run through for me what exactly did Ms. Graham do from arrival on the scene during transport of Mr. Goode to the hospital, things that she did do. We'll talk about the things you say she didn't do later, but let's focus on what she did do.

A. Okay. Well, certainly we can go right through the report itself, is that she did provide him some medical treatment, she indicated that she did an assessment, the specificity of the assessment isn't really identified.

She indicates that she put him on a cardiac monitor, it showed an SVT, she identified that. He was not provided any oxygen, but you asked me to let that go for now. She takes an initial set of vital signs and monitors his PsO2 and SpO2, that's the oxygen saturation level in his blood line. The record indicates that she started an I.V., and then at that point pretty much then stepped back and didn't provide him a lot more therapy after that.

There is no indication that she provided him any oxygen, but she saw an SVT, she took an

initial set of vital signs, and then she left him in the position that he was in. So very little did she actually do.

Q. The SVT, the supraventricular tachycardia, that's an elevated heart rate?

A. Yes, sir.

Q. Was Baptist informed of the SVT through Ms. Graham, to your knowledge?

A. I don't know the content and quality of that record, that audio record or whatever she sent them. I don't know that.

Q. You state there was a significantly accelerated and life-threatening heart rate. Is that what you're referring to, the SVT?

A. Yes, sir.

Q. What was the heart rate at the time it was checked in the ambulance?

A. Her record indicates, well, I look at the, if you look at the report, there's one on the back here, this is around 150, 156, I mean, it gives the number in the top of the record, but if you know how to read these, you can see he's well over 150 beats per minute.

Q. That's during the ambulance ride itself?

A. Yes, sir. That's what I'm aware of.
Q. Then was his heart rate checked upon admission to Baptist ER?
A. I would have to go back to the hospital records, but the primary focus of my involvement was what happened before those thresholds.
Q. So we can compare the heart rate as measured in the ambulance ride to the heart rate measured at Baptist to determine whether or not it stayed consistent, increased or decreased, correct?
A. You could use those comparatives. If you go back to her report, at 20:20 the heart rate is at 164. Five minutes later, it's now 186. So in five minutes, his heart rate is accelerated 22 more beats per minute. His heart rate is continuing to move up.
Q. When was the 150 to 156 measurement?
A. This record, I don't know if they stamped it or not. Let's take a look. This says 20:10:57. So that would be consistent with, he first got it, so she puts it on him, he's at 156, that's at 10, 10 minutes later he's now up to 164. Five minutes later he's now up to 186.
Q. Was there any other testing of his heart

rate during the course of the ambulance ride, to your knowledge?

A. Testing in what way, sir?

Q. The determination of beats per minute. Those are the only ones we're aware of?

A. Yeah, these are the only ones that I'm aware of. 20:20, 20:25 are what she puts in here as being SVT.

Q. And how did she determine the heart rate, what type of device did she use?

A. Well, there's a couple of different ways. You can check your pulse, first of all, that's one. The second one is she used a cardiac monitor, she placed the three leads on the patient, there was actually four that go on, the fourth one is a ground, but she places three leads on the patient through which she can get a general view of his cardiac heart rate. Lead two is the most commonly used, it tells us very clearly what the heart is doing and it allows us to make a differential diagnosis on what's going on with the patient.

Q. Do you have any knowledge as to whether Mr. Goode was continuing to struggle, thrash around,

yell, things like that during the course of the ambulance ride?

A. Yes, sir.

Q. What do you know about that?

A. That he did continue to thrash and fight and fight against whatever he thought he was in. I mean, there are statements made, I think Ms. Goode, or, excuse me, Ms. Graham is the one who says he doesn't even know that we're there. He's just acting out.

Q. Was he yelling during the course of the ride?

A. Yes.

Q. Do you know if he was making any threats?

A. Well, that's in debate. Ms. Graham says he was. In fact, I think she even quotes him as saying that, she indicates that, she says, Mr. Goode says if I get out of here, I'll kill all of you.

Well, the police officers don't substantiate that. When they were asked, they said, no, they never heard that. They were in the back of the ambulance with her. There's also a statement that says Mr. Goode had no idea who was around him.

He was talking out of his head.

So if I tell you if I get out of these chains, I'm going to kill you, I have to be aware that you're there. You know, and the other testimony is to the point where they don't even, he doesn't even know where he is.

Q. I know you referenced that in your report, we may talk about that as well, but are you okay?

A. I have a screw in my elbow and if I ding it the right way, I know about it.

Q. Do you not believe Ms. Graham's account that there was a threat made by Mr. Goode?

A. Well, I think it's up to who you believe. She says it. The police officers say they never heard it, and she contradicts in saying he doesn't know where he is. So whose story do you buy? I don't think Ms. Graham was in any danger whatsoever.

Q. Would you agree, though, her perception being at the scene may have been different than yours?

A. Well, her perception may be different; however, she's supposed to have been trained how to

function within these environments. She is in a controlled environment, she has two police officers less than a few feet away from her. Her job is to manage Mr. Goode in the appropriate fashion.

Q. Do you have any criticism of her education or training?

A. Well, she's certified as a paramedic, so she is supposed to know what's going on in these protocols. She's supposed to function within these protocols. It appears she's been trained appropriately. Did she act appropriately? That's what our discussion is about.

Q. Right. Now, you state here, further Mr. Goode's blood saturation level upon entering the emergency department was 90 percent.

A. Yes, sir.

Q. Do you have any knowledge as to what his normal baseline O2 sat level might have been?

A. Yes, I can. I mean, you and I sitting here and Mr. Goode sitting in his room is going to be right around 90 to 100 percent. If he's not, we've got some problems and he's going to be seen. So to be at 90 is a problem.

Q. For someone who's had physical exertion

or who's been yelling, does that make any difference in an O2 sat level?

A. Sure, it will bring it down, but also we see now two things are starting to happen. He has an accelerated heart rate. That heart rate is pumping up. If you think about an impeller pump, that impeller is moving so fast that he's not able to circulate blood volume, he now becomes oxygen deficient. So his hypoxia is kicking in.

If he's laying on his chest, he cannot possibly inhale deeply enough to offset that margin. You think about excessive running or activity. Well, what do we do? We're standing up or we might bend over a little bit, but we're allowing our chest wall to expand to pull in that new oxygen. Being in a hog-tied position, Mr. Goode never had that opportunity.

Q. In your experience, does smoking include smoking marijuana cigarettes, can that affect the ability of your lungs to take in oxygen and reduce your O2 sat levels?

A. Well, I think there is some disease process involved, but I don't know that that applies in this case.

Q. Were you aware that Mr. Goode did frequently smoke marijuana?

A. I think I had read something to that effect, I don't recall. But we're talking about the here and now, you know. I had a cigar last night sitting in the backyard. It doesn't mean that my pulse oximetry today is lower.

Q. Upon arrival to the ER department, you say his blood saturation level was 90 percent, are you aware of any supplemental oxygen being provided at any point in the Baptist ER?

A. Once again, sir, once I transferred past that threshold, I didn't look at them too much. I mean, he was, apparently tried to be given some, and I don't recall the specifics. My focus was what was on the back of that ambulance.

Q. Okay. So again, you've not reviewed all of the Baptist ER records?

A. I went through the initial induct into where he was brought into the system, he was evaluated by the ER physician, he was drawing a crowd because of his misbehavior, he was put into a separate isolated room, and the only one supervising him was a police officer.

He was given some medication, and then abandoned within the emergency department by the medical staff, and left in a room with a police officer.

Q. Now, based on your -- I want to go back. We talked about it a moment ago, but based on your review of all the records in this case, and the deposition testimony, at which point exactly was Mr. Goode transferred from EMT care to ER care?

A. Once that physician put his hands on him or his nurse or the nurses put their hands on Mr. Goode, and it is understood by Ms. Graham that they are now directing his treatment, she's out of there.

Q. You state, in part, that prolonged hypoxia or low oxygen saturation levels will lead to a lethal cardiac arrythmia if not corrected. How long, in your experience, would the hypoxia have to occur, how prolonged would it have to be potentially to lead to some type of cardiac event?

A. Well, that's patient determinant. It really is patient determinant. You can't say five minutes, 10 minutes, that is inaccurate. There are a number of different physiological things that you have to pay attention to, how long has this

individual been having respiratory difficulty, what is their ability to have adequate ventilation. It's not respiratory rate, it's the adequacy of the ventilation that's important.

And then, depending on what other activities are going on, Mr. Goode here is thrashing and fighting about, he's becoming more and more acidotic, which causes other problems. The respiratory rate will pick up, there's a whole cycle here that happens. So I can't give you a five minute, 10 minute, it's situational.

Q. Let's go over to Page 5 of the report then under background.

A. Yes, sir.

Q. You state that Ms. Graham held a position of public trust as an emergency responder. What do you mean by that term, public trust?

A. Well, when people call 911, they have an expectation that the people who are going to show up on their door or show up in the street have a level of training and experience to where they can manage their problem. The public trusts us when we show up to take care of their problems.

Q. You state down further in that same

paragraph, Stacie Graham had a duty to act; however, she made a conscious decision not to do so. I want to be sure I understand what you're saying there.

Are you saying that she made a conscious evaluation of the care that Mr. Goode needed or didn't need, or are you saying that she consciously decided to deprive him of medical care knowing that he needed it?

A. Yes, sir. That's exactly what I'm saying.

Q. You're saying that she knew that Mr. Goode needed care but made a conscious decision not to give him that care.

A. Yes, sir.

Q. Okay. That's what I want to talk about then, your opinions in that regard and what you base those opinions on.

A. Yes, sir.

Q. If you could just sort of walk me through all of your criticisms and opinions concerning Ms. Graham, and I'll follow up with some questions.

A. Okay. Well, she knows and she testified that she knows that Mr. Goode should not have been

transported in the prone position, she knew it. But she even says, at one point she says that there's protocols. She admits to knowing that she's violating the protocol. She says that she just didn't do it. So she knew there was a way to manage it, and let me put it this way. Ms. Graham had an opportunity to save Mr. Goode's life. One of the first things she could have done is get him on his side, get him moved. So she had an opportunity to save this guy's life, but she made conscious choices not to do it.

The first one, she didn't rotate him 90 degrees to get him on his side. The second one is she didn't use the chemical restraints that were available to her to knock down his aggressive behavior. The protocols are very clear that patients, that problems can happen if you don't control this thrashing, fighting. She chose not to give him the medication. It's in her deposition. It's quite clear that she was able to start the I.V.

Now, and here's one more thing. None of these interventions are highly technical, they don't require some high level training, they don't require special equipment. She had all of these tools in

the back of the ambulance with her to fix the problems, yet she admits to not doing it. So there are my criticisms.

Q. She don't rotate, did not use chemical restraint?

A. Yes. She didn't provide him any oxygen, I mean, he needed oxygen, she had a pulse oximetry of 90. If you look at the Mississippi protocol, the Mississippi protocol, this is, what do they call this one, what number did they give it?

Q. They said he had a pulse oximetry of 90 during the course of the ambulance ride?

A. Yes. She would have had to, she says there's an initial one, and moderate hypoxia, that's identified as moderate hypoxia, 90. Here's the protocols in response to that.

Immediate need to increase the delivery of oxygen in a patient. Now, I understand where she says that you wouldn't keep it on, that, let me find it. Let me find it.

Q. That's the SpO2?

A. Yes. The oxygen level. I identify the protocols, we'll go to that, but let me go to more of the testimony that I want to identify.

She said he wouldn't keep it on, that he wouldn't keep the oxygen on because he was thrashing around. No kidding. I mean, if he's thrashing around, the mask is going to come off. And then she makes the statement, this is one of the statements that blew me away. She says her rationale for transporting Mr. Goode in the prone position, she says, well, you can transport patients in a prone position. It's to the patient's comfort, and, hey, everybody sleeps on their stomachs. That's ridiculous.

Q. You're reading from her, an excerpt from her deposition, correct?

A. Yes, sir. And that, so that tells me her mindset here, that she thinks this is perfectly fine, yet her protocols tell her absolutely not, the national literature says absolutely not. There is no literature that I'm aware of that says leaving a patient in a prone position is acceptable. But yet, she chooses to do it. That's a conscious decision she made.

Q. She's giving an explanation in her deposition as to why she made that decision, correct?

A. Yes. Because people sleep on their stomachs. Well, when I'm sleeping on my stomach, I'm not in a hog-tied position, I'm not thrashing about against restraints. I'm not on some chemical that I ingested. This rationale is, it's beyond the pale. I simply cannot justify this in any fashion.

Q. Is that, if you are ranking your criticisms of Ms. Graham, so I understand it, would that be your number one criticism, this transportation in a prone position?

A. Well, I'll tell you one and two are real close, but absolutely, that's number one. Especially when the protocols on physical restraint, number 16 and 17. Number 16, now, there's, the procedure is 605, protocol 605. There is no ambiguity here. I mean, I don't need to be a trained EMT or paramedic, someone on the street could read number 16 which says, "Do not", in capital letters and bold, "restrain patient in a hobbled, hog-tied, or prone position". Number 17, in bold letters, capital letters, "Do not sandwich patients between devices, such as long boards or Reeve's stretchers, for transport. Devices like backboards should be padded appropriately", and they

didn't do that, but it's still very clear on leaving a patient in a compressed position.

And then number 20, 20 says, "Never apply restraints near the patient's neck or apply restraints or pressure in a fashion that restricts the patient's respiratory effort". Being in a prone, hog-tied position absolutely restricts a patient's respiratory effort.

Q. This SOP 605, does that, is that not speaking to a situation where EMTs are actually the ones restraining a patient at the scene?

A. No, sir, that doesn't indicate that at all. It says this is how you're to transport patients who are restrained. Then what's important too is on the next page where they start to weigh into chemical restraints, and it says, number 2, and this is important, "There is a risk of serious complications or death if a patient continues to struggle violently against restraints". Mr. Goode meets all of that particular criteria.

Chemical restraint by sedation may be indicated in some dangerous, agitated patients. Now, Graham says he is that. Graham identifies him as dangerous, she was in fear. But what doesn't

make any sense here at all is that she was able to infuse an I.V., which requires up close and personal contact. Once you put that I.V. tubing on, there's a port 12 to 18 inches away from the patient where she wouldn't even be close to administer some medication to bring Mr. Goode down out of that aggressive nature. But she chose not to do it.

Q. Did Ms. Graham talk about in her deposition the type of potential chemical restraints that were available to her?

A. Well, it says in their protocols, it's in the protocols, that she had Valium or Versed.

Q. Going back to SOP 605 just a moment, though, when you read through the first, say, 2, 3 and 4 portions of that, aren't those speaking to EMTs who are themselves going to restrain a patient when it tells the EMTs, use the minimum amount of force, assure adequate personnel are present and that police assistance has arrived. Plan your approach and activities before restraining.

Those are telling the EMTs, if you're going to restrain a patient, here's how you do it, correct?

A. Yes, sir.

Q. Also, number 1, what is the main priority under this SOP?

A. Well, the main priority, according to number 1, safety of fire department/EMS personnel is the main priority; however, that does not relieve them of their responsibility to make sure the safety of the patient is addressed as well.

Q. Under the SOP, safety of fire department/EMS personnel is the main priority in any situation where a patient exhibits aggressive or combative behaviors and needs to be restrained.

Now, you would agree in this case that Mr. Goode exhibited aggressive or combative behaviors?

A. Well, not in this, because when the fire department got there, he was already restrained. His initial aggressive behavior was towards the police officers and the potential public. So there was no threat to the fire department personnel. He was already hog-tied.

Q. Prior to being placed in police custody, you would agree he exhibited aggressive or combative behaviors?

A. I guess you could interpret that.

That's situational as well.

Q. And if he's making threats to individuals, I'm going to kill you if I get loose, things like that that have been recounted by other folks in depositions, would that be considered aggressive or combative behavior?

A. That's only recounted in one deposition, and that's Ms. Graham. The police officers who were in the room, probably closer than you and I are sitting today, sir, in the back of the ambulance, and I'm very familiar with the confines of an ambulance, those police officers never heard that. Two of them.

Q. What about personnel in the Baptist ER, have you read any depositions of any nurses or other personnel who indicated he was, in fact, making threats or screaming?

A. There is no question he was screaming, he was hallucinating.

Q. You agree that Mr. Goode needed to be restrained, you just have a difference of opinion as to how he should have been restrained, is that an accurate statement?

A. That's not just my opinion. I mean,

it's also the opinion of the protocol. And it's also the opinions of the nationally accepted texts that are out there. Let's talk about Essentials of Paramedic Care, Second Edition. This was written in 2007. Here's what the texts talk about when it talks about aggressive patients. Then it says EMT/paramedics, patients should not, italicized, be transported while restrained in a prone position. Restraint in a prone position has been associated with positional asphyxia. In addition, nothing should be placed over the face, head or neck of the patient.

Now, let's go down a little bit further because this is important and it gets to your point of the protocol. It says, as soon as the team has control of the patient's movement, however, the team must work to move the patient into a supine four-point restraint position on his back. A patient should never, again, italicized, be hobbled or hog-tied with the arms and legs tied together behind the back. During transport, a patient should never, again, italicized, be restrained to a stretcher in the prone position or sandwiched between backboards or mattresses, they didn't do

that. Once the patient has been restrained, he should never be left unattended.

Here's another thing. A patient who has undergone physical restraints should not be allowed to continue to struggle against the restraint. Struggling against restraints may lead to severe acidosis and fatal dysrhythmia.

In general, for the safety of the patient and the EMS personnel, physical restraints applied in the field should not be removed until the patient is in the hospital. I can buy that. That's not a problem.

The other point in chemical restraint, the goal is to subdue the patient's excessive agitation and his struggle against physical restraint, because we know what's going to happen if we let this guy fight. That's just one reference. We talk about the other one, Emergency Care in the Streets. Emergency Care in the Streets, this is written in 2011. It says, never place your patient face down because it is impossible to adequately monitor the patient, and this position may inhibit the breathing of an impaired or exhausted patient.

And then lastly, when preparing to

secure the patient to the stretcher, it is of the utmost importance to have the patient in the supine position. If the patient is placed in a prone position, a condition called positional asphyxia can develop. In prone positioning, the increased weight of the patient's lungs or his or her inability to fully expand the thoracic cavity could render the patient unable to breathe creating a preventable, life-threatening emergency.

So it's well documented that he never should have been left that way.

Q. The articles that you've cited in your report, are those all of the articles and materials that you've relied upon in this case?

A. Well, sir, these are textbooks, they're not articles. And then we get in the American Heart Association where they talk about the SVT, the dangers of that, these two textbooks are the primary indicators I've used. There are a series of articles that talked about transporting violent patients, and I read these as a reference but I don't cite these in the report.

Q. The two that you do cite there, you just held up, would you identify those again for me?

A. Yes, sir. The first one that I read is Essentials of Paramedic Care, I think you have it identified as 10.

Q. Right.

A. And I don't know what you have identified as Emergency Care, sir. It's the orange one, on the very back there, that's identified as 5.

Q. 5.

A. 5. 5 and 10 are the two that I have spoken about.

Q. So to understand your position on the protocols, do you view those as absolute rules or guidelines for use by the EMTs?

A. Well, they have dual functions. These are the, let's see what the record says. I'll let that speak for itself. It says, let me go back. The protocols say, I apologize for the delay.

Q. That's fine, take your time.

A. Okay. Here's what it says. On Page 5. "The Southaven fire and EMS department have, as a part of the operational directives", and the question was are these absolutes or can they do what they want.

Q. That wasn't exactly my question, are

they absolutes, are they guidelines which can be deviated from based upon the discretion of the EMT?

A. Well, these are the fundamental aspects in which they are able to function under. It says that these procedures are promulgated by the State of Mississippi, Division of Emergency Medical Services, and the first paragraph in the introduction states this. "These standing orders and protocols are to be used by EMS personnel licensed by the State of Mississippi, Division of Emergency Medical Services, to render appropriate care". Then in Section 11, EMTs are expected to perform their duties in accordance with these rules that were generated.

Q. "Expected to perform their duties in accordance with the local, State and federal guidelines in accordance with the State of Mississippi statutes and rules of Mississippi emergency services".

A. Yes, sir.

Q. That would include those protocols?

A. Yes, sir. That's right out of Article 11 of the protocols.

Q. Are there any other local, State,

federal guidelines, statutes or rules other than protocols that you reviewed in this case or which you think might be applicable to Ms. Graham?

A. Well, what we're talking about here is pretty good, and I can bring all of those in. The local and State protocols are these. This is it.

Q. You just held up the --

A. Mississippi Emergency Medical Services Standard Operating Procedures. And there's 248 pages of them. Certainly not all 248 pages are applicable to Mr. Goode. I don't want to suggest that. But here are the local and State things.

Now, there are, I can't find you a federal rule that says this, but what I can provide for you is a federal standard of care where it is promulgated, here's what's happening across the United States. I mean, nobody, there is no protocol that I'm aware of, even my own, that allows for a patient such as Mr. Goode to be transported in a prone position for all the clearly and widely known reasons why you don't do it.

Q. Just for the benefit of the attorneys on the phone, the documents you held up as indicative of a national standard of care?

A. 5 and 10.
Q. Exhibits 5 and 10?
A. Yes, sir.
Q. So, again, I guess going back to my original question then, are the protocols absolute guidelines which must be followed, excuse me, absolute rules which must be followed, or are they guidelines provided to EMTs which can be deviated from in some situations based on their discretion?
A. No, sir.
MR. McCORMACK: Object to the form.
You can answer.
A. It's very clear they're expected to perform their duties within these guidelines.
Q. Let's go to Page 6 where we talk about protocol 202.
A. Yes, sir.
Q. Drug ingestion. Now, you've referenced that protocol, you state on the top of the next page the things that Stacie Graham, you believe, failed to do. One, conduct a complete patient assessment. Do you have that in front of you? I just want to go through those with you then.
In regard to protocol 202, drug

ingestion, what did Stacie Graham fail to do in regard to patient assessment?

A. What is not noted here, we have to use her record. This is the record she generated, she did take a blood pressure, she had a pulse, she had a respiratory rate. There is no documented SpO2, there is no documented blood glucose number, I mean, what was his glucose? That's important. It can't be just discounted. These are all pieces of the puzzle that, when brought together, give you what is going on with the patient. You can't just discount all of these.

I have worked with patients who are violent and thrashing. These are things that can be done. You just have to use your training and do them. So my criticism in 202 is she didn't complete the completed assessment. She didn't provide oxygen to Mr. Goode. He didn't get it. She didn't do a blood glucose check. Is it an absolute that, hey, there might be some indication on why Mr. Goode is acting out. For example, hypoglycemic patients, low blood sugar, can act extremely violent as if they're, in fact, having an overdose or some other problem. Or simply knowing a blood glucose level

can say, well, here's our problem. Give him some D50 and let's bring him out of it. So that's an important variable.

Q. That's what I wanted to ask you, what the significance of a blood glucose check would have been to you.

A. The significance is that on hypoglycemic patients, they do have an altered mental status and they can be fighting as if there's a belt on the line. So what has to happen is that we have to raise their blood sugar back up. So it is possible, it is possible that Mr. Goode had a hypoglycemic problem, but we don't know that. It's our job, EMS' job to start filtering out what's wrong with this guy, and is that one of the elements, no or yes. But in this case we don't know.

Q. So the glucose check would have been essentially to rule out hypoglycemia as the cause of his acting out?

A. It could have been a potential cause, absolutely.

Q. So then we talked about failure, in your opinion, to monitor the O2 sat levels, we have talked about conducting a complete patient

assessment, correct?

A. Yes, sir.

Q. Provide oxygen and airway maintenance. During the course of the ambulance ride, are you aware of any physical indications that would be visible to me or to a police officer or to Ms. Graham, of Mr. Goode having difficulty breathing? If he's yelling, for instance, is that indicative of a problem breathing or adequate oxygenation?

A. That's a great question, and the answer is I have no expectations of the police officers being able to see and/or recognize medical conditions unless they're trained in that.

But he is yelling. Now, a respiratory problem, for example, could be one's statements or one's words don't tell me definitively that he has a good airway or that he's being ventilated well. For example, a patient who may holler "help", that's not indicative of whether or not they have a good pulse ox or not. I mean, you have to determine that.

Someone who is conversing like you and I are, sir, all as an observer, I can tell you pretty much your and my airways are ventilating pretty well. But if someone is screaming, that wouldn't

surprise me. I have had patients who are in dire straits who are able to scream because they're on, you know, they're having a lot of problems. So the fact that he's screaming, I don't think that that will tip it one way or the other.

Q. Even if the screaming continues for 30 minutes or in excess of 30 minutes?

A. I would expect him to be hollering, certainly. I mean, that does not mean that he's not becoming hypoxic.

Q. Are there any other criticisms then in regard to SOP 202, drug ingestion, other than the four we've talked about?

A. No. I brought that in because I think it starts to show a pattern, now there's a pattern here that's developing. As we continue, there are more and more omissions in Ms. Graham's treatment of Mr. Goode, it sets a pattern. She chose not to do these things.

Q. There are two other SOPs that you referenced in here that you believe were violated, 605 and 612.

A. Yes, sir.

Q. I want to do the same thing with 605,

we've talked about it a little bit already, the physical restraints?

A. Yes, sir.

Q. Other than the opinions you've already given us that Mr. Goode should have been moved onto his side, is there any other criticism you have in regard to SOP 605 on the restrained issue?

A. Well, yes. I believe I spoke about that. Getting him off his back, or getting him off his stomach is certainly a number one priority, right there when we start talking about the chemical restraints, it's very clear in identifying that chemical restraints can be used here.

It is on the second page of that protocol that says that there is a risk of serious complications or death if a patient continues to struggle violently against restraints. Chemical restraint by sedation may be indicated in some dangerous agitated patients. And then it gives you 3, 4 and 5. 4 is very clear, in that Valium, 2 to 5 milligrams I.V. or Versed, 2 to 5 milligrams I.V., or I.M., that's even a better one. If you look at Versed, she wouldn't have had to stick it in the vessel. She could have stabbed him in his buttocks

or in a big muscle such as the deltoid to deliver that medication, which would have brought him off of his aggressive demeanor. But she states in her testimony she consciously chose not to do that.

Q. Does she state why, why did she consciously decide not to do it?

A. She thought she was in fear of her life. And it doesn't wash, because she started the I.V., which required up close and physical contact with Mr. Goode. And as I mentioned a little bit earlier, she could have given both of those medications 12 to 18 inches away from the physical contact of Mr. Goode. So she could have sat back in the seat and given him the medication.

Q. She was also, they were transporting him to the ER for higher level of care where chemical sedation would also be available in your experience, correct?

A. Yes, sir.

Q. Would it not be better to have that sort of medication administered by a nurse or a physician or under the order of a physician?

A. Well, two things. She already has the order of the physician right here in the protocols.

This is the order. She's allowed to do it. No, it would not have been better. Time is of the issue here. The longer he fights, it says it very clear, there's a risk of serious complications or death if a patient continues to struggle violently against restraints.

So the whole time he's in the back of that ambulance, it's contributing to that very sentence, his risk of death is growing.

Q. Now, it states in number 2, chemical restraint by sedation may be indicated in some dangerous, agitated patients. Now, that "may", the use of the word "may" is discretionary, is it not?

A. Well, it may, yes. She sets the tone. Because she identifies him as dangerous, agitated and, I mean, she says it. He's aggressive, man, we've got to do something. She's identified it.

Q. But a moment ago you sort of discounted her description of him as being dangerous and aggressive.

A. Well, I discounted because I don't believe it's accurate. I mean, he is of no threat to her. She says that he's this way. That's her interpretation. But this protocol applies because

she's identified Mr. Goode as dangerous and agitated. She says it. So then use the chemical reactant. She says that she chose not to do it. That means she knew that she could do it.

Q. The protocol says, may be indicated in some dangerous, agitated patients. So it doesn't require it in all cases where the patient may be dangerous or agitated, correct?

A. Well, "may" is an operative word, sure. But this is a case where he clearly needed it, she knew he needed it, but she made the choice not to do it.

Q. So you would agree "may" does give discretion to the EMT in the decision whether to administer some type of chemical restraint or not?

A. I don't know that it gives them discretion. It says, that's the way it's written, may be indicated. This is one of those cases where it is indicated. There is no question about it.

Q. Are you aware as to whether or not Mr. Goode did receive some type of medication to calm him in the ER?

A. Yes.

Q. How long would that have been after he

arrived and was transported from EMT care to ER care?

A. It was within a few minutes. I think the physician here gave him Haldol. I can't remember the exact dosage of Haldol that he gave him, but the question then is why would he have given it to him. The reason he gave it to him was to break him out of this aggressive, agitated state. The docs knew it. She knew it. But it took all that much more time before he was administered until he got to the emergency department.

Q. Again, just based on your review of the documentation, how long was Mr. Goode in the emergency department from the time care was tendered by the EMTs until he passed away?

A. I think he was found to be in cardiac arrest, my papers are going everywhere. I think he was found in cardiac arrest somewhere around, it's after 20:33 because at 20:33 they have an SpO2 of 90 percent. I don't have a time here when they started giving the medications.

Q. So earlier you said it was a few minutes after he arrived, it may have been longer than that?

A. It may have been a bit longer. I don't

have that. I know that he arrives in the emergency department at 20:28 and is pronounced dead at 21:44. I don't have all of those times enumerated and, again, because it's not what I was asked to --

Q. We can agree he was in the ER approximately an hour?

A. I'm not going to agree to anything until I can verify it. If you're telling me that that's the record, then I have no reason to believe you're lying to me.

Q. I'm not going to represent anything to you in the course of your deposition. Okay. I want to make sure, is there anything else in regard to SOP 605, other than what we've already talked about, any other criticisms of Ms. Graham, any other opinions you would hold in regard to that protocol?

A. Well, I think I've articulated my positions. I don't see a need to regurgitate them again just for both of our sake.

Q. I agree. I just want to make sure we have covered all of your opinions in regard to that particular protocol.

A. Yes, sir.

Q. The next protocol would be SOP 612 which

is titled excited delirium taser use. Would you agree that this protocol recognizes excited delirium as a condition?

A. It does. This word is transferred back and forth, and I think it's clearly pointed out, you know, agitation as well. I mean, this, it is termed here excited delirium, I've read excited agitation as well. It may be nothing more than semantics.

Q. Are you aware there is a diagnosis of excited delirium or a condition called excited delirium?

MR. McCORMACK: Object to the form.

You can answer.

A. Yes, I am.

Q. You're not sure that's what this refers to, though, is the actual condition?

A. Well, it depends on, like I said, this is, if you look at the symptoms, changes in loss of consciousness, ongoing disorientation, agitation, hallucinations, these are all similar symptoms that Mr. Goode is exhibiting. Some facilities call it excited agitation, others call it delirium.

Q. And in any regards, SOP 612 deals with the situation where a patient has been tased?

A. Well, I don't know that that is inclusive of both. I think it may be, here's one and another. The protocol itself isn't, doesn't write about tased. I mean, it just talks about these conditions and how to manage them. Why taser use is attached, I'd have to ask the author.

Q. In referring to your report, you say, records including Mr. Goode had been tased by a police officer. Due to that fact, Ms. Graham was required to follow protocol 612 as well.

So in reading your report, my assumption was that's why you referenced 612, was your belief that he, in fact, had been tased.

A. And we talked about that, yes. So that brings in all of these other assessment tools of EKG monitoring, oxygen saturation, Valium. Those are all things that would have been able to intervene or help in the condition that Mr. Goode presented to her.

Q. Given that introductory language you had about due to the fact he was tased, this protocol applies, if he was, in fact, not tased and there was no shock delivered, would you believe protocol 612 would still be applicable?

A. Yes.
Q. You have listed in that regard five things that you believe Ms. Graham failed to do, we've gone through those. I believe you have covered every one of these in your prior criticism as well, correct?
A. Yes, sir.
Q. So there would be no new criticism based on your belief that she violated 612 other than what we've already talked about, provide oxygen and airway maintenance, supportive care, as she didn't reposition Mr. Goode from a prone position, assess blood glucose level, monitor oxygen saturation levels, provide Valium to calm Mr. Goode, right?
A. Yes, sir.
Q. We've talked about all of those?
A. Yes, sir.
Q. And would your opinions about those matters be any different in regard to protocol 612 than they were in regard to the other protocols we've already talked about?
A. No. But what this does, though, is start drawing a connection. Here are a number of protocols that I've identified that have similar

conditions that she didn't attend to.

Q. You made a statement earlier that related to Mr. Goode's death, I just want to be clear. Now, we all agree Mr. Goode did not die during the course of the ambulance ride, correct?

A. Well, he didn't die, but he was getting sicker and sicker and sicker and he was climbing the ladder. And this is where my position is. Ms. Graham had an opportunity to save his life, and she didn't do it. The series of events from the onset of his position on led to the problem, and once the circle starts spinning, there comes a point where it doesn't stop.

She could have intervened on two occasions, at least that we know of, the simplest one, turning him 90 degrees, get him on his side so his chest can expand. The other one, which she admitted to knowing, is using the chemical restraint to get him to stop fighting.

If you backtrack that just a little bit, had Ms. Graham done the two things that could have saved his life, he wouldn't have been stuck in a holding room with a physician after been given Haldol and left to himself where, the next time they

find him, he's in cardiac arrest.

The reason he was moved into that room is because he was creating a scene in the emergency department. Backtrack a little bit and say, look, if Ms. Graham would have given him a medication to calm him, he never would have been put in that room, he would have stayed where he was and had monitoring.

So she had an opportunity to save this man's life and consciously chose not to do it.

Q. Through not repositioning him on the side, not administering chemical, some type of chemical sedative?

A. Those are the two. Then give the guy some oxygen, let's bring his heart rate back down. You've got to bring these things down. The dominoes are falling, sir. And she doesn't do anything to stop the dominoes. She was in a position to do so.

Q. You said we're climbing the rungs of the ladder, I think is what you said?

A. Yes, sir.

Q. When Mr. Goode arrived at the Baptist ER, though, you're not taking a position that he was not, he was in a critical or terminal condition, are

you?

A. He was absolutely in a critical situation, yes, sir. Because all of those events have now lasted 20-some minutes or longer. I mean, and the longer those last, the more critical he becomes. So by the time he gets into the emergency department, he's in a very precarious position.

Q. I want to be sure I understand your opinion. I believe it is, despite what may have happened or not happened in the ER, you blame Mr. Goode's death on Ms. Graham?

A. Well, I think it's a total event. It's a total event. If Ms. Graham's intervention could have come in earlier, they could have, she could have stopped the wheel from spinning early. The wheel was still spinning by the time he ended up in the emergency department, then it goes downhill from there.

But her interventions, her early interventions, that's the whole point of emergency medical services, the fact that ambulances are stocked with the equipment and the tools and the personnel that they are was to bring the emergency department to the bedside of the patient out in the

field. She had the tools to do what was needed to be done, she didn't do it.

Q. The remainder of your report, Page 11, 11 and 12 is where you get into the opinion. I think, as we've gone through the report, we have covered your opinions, correct?

A. Yes, sir.

Q. So in looking through the bottom of Page 11, Page 12, and Page 13, just above your signature, have we already covered, through your testimony, all of the opinions that you hold in this case?

A. Yes, sir.

MR. DILLARD: Let's go off the record, let's take a short break, I would like to look through my notes for just a moment.

MR. McCORMACK: Okay.

THE WITNESS: Okay.

(A brief recess was taken.)

Q. During the course of your examination, Mr. Krause, have we discussed all of the material that you have reviewed in reaching your opinions?

A. Yes, sir.

Q. And have we discussed all of the

material that you have actually relied upon in reaching your opinions?

A. Yes, sir.

Q. Have we fully discussed all of the opinions that you hold in this case and which you may offer at trial?

A. Yes, sir.

Q. And we've fully discussed the basis for each of those opinions, correct?

A. Yes, sir.

Q. To date, for your work performed, how much have you charged and been paid?

A. I think we're right around $5,000.

Q. Does that include the deposition fee that my office paid, or is that separate?

A. That's separate.

Q. I see your rate of compensation for review is $250 per hour. Does that apply to all work you perform including, say, travel and attendance at trial, or is there any different fee structure?

A. There is no different fee structure.

Q. So if it's $250 per hour, it's when you leave Toledo until you come back?

A. Well, I don't do that. And my fee structure tells you that. I think that's nickel and diming you to death, and I don't think that's fair to the attorneys.

I have a travel day, which is a flat $1500, I have a trial day which is a flat $2,000. I don't bill you for sleeping, I don't bill you for walking. I think that's unfair.

Q. Okay. So for those events, it is a flat fee?

A. Yes, sir.

Q. Got you. But your review work, generating a report, things like that, would be at the $250 an hour rate?

A. Yes, sir.

MR. DILLARD: Mr. Krause, I'm going to tender you over, if any of the attorneys have any questions.

THE WITNESS: Thank you, sir.

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EXAMINATION

BY MR. McINTOSH:

Q. Mr. Krause, my name is John Martin McIntosh, I represent the defendant Baptist Memorial

Hospital - DeSoto, Inc. Are you able to hear me okay?

A. Yes, sir, I can.

Q. I have a few questions for you. If we cut out or you don't understand a question I ask you, please let me know, okay?

A. Yes, sir.

Q. Mr. Krause, as I've reviewed your report and appreciated your testimony here today, it is my understanding that your opinions in this case are limited to the pre-hospital paramedic care of Mr. Goode, is that correct?

A. Yes, sir.

Q. That is, you don't plan to offer any opinions concerning the nursing or physician care and treatment rendered to Mr. Goode in the emergency department, do you?

A. No, sir.

Q. You have no nursing or emergency physician training, do you, sir?

A. Well, I did attend nursing school, yes, sir, but I am not --

Q. Did you obtain a nursing degree?

A. No, sir. I'm not an R.N. I left

nursing school to pursue the pre-hospital aspect of medicine.

Q. Would I be correct, sir, that you're not holding yourself out in this case as an expert in emergency department nursing or emergency medicine as practiced by emergency physicians?

A. That's correct, sir.

MR. McINTOSH: Thank you, sir. That's all the questions I have for you.

THE WITNESS: Yes, sir.

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EXAMINATION

BY MS. WADDELL:

Q. Mr. Krause, this is Amanda Waddell, I, along with Mr. Gass who is also on the line, represent Dr. Oliver. And just to follow up with, on Mr. McIntosh's questions, just to make sure the record is clear, you are not a licensed physician, correct?

A. No, ma'am.

Q. And you have neither attended nor graduated from any medical school, correct?

A. That's correct.

Q. You have never worked as a physician,

correct?

A. No, ma'am.

MS. WADDELL: That's all I have. Thank you.

THE WITNESS: Yes, ma'am.

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EXAMINATION

BY MR. McCORMACK:

Q. Mr. Krause, my name is Kevin McCormack, as you know, I represent the plaintiff Troy Goode's widow, Kelli Goode, and his minor child. I'm going to have a few questions for you.

There's a diagram in your report on Page 3 that you were asked about, it's this red diagram on Page 3. Do you see that?

A. Yes, sir.

Q. You've called that the hog-tie position?

A. Yes, sir.

Q. You also say that it was called the four-point restraint by Southaven Police Officer Baggett, is that accurate from your report?

A. Yes, sir.

Q. When EMS personnel talk about a four-point restraint, is this what they talk about?

A. That's exactly what they talk about. The flip of that is when they're on the cot on their back, we've restrained all four limbs, but that's clearly different than what these images are.

Q. So what are EMS personnel trained to do for a four-point restraint?

A. Well, the ambulance approach to a four-point restraint with the paramedics and EMS personnel is to get them over on their back so they're on their back, they can have chest expansion.

But to take each of the four limbs and restrain those individually using soft restraints and securing them to the cot so they can't move off of the cot, then use the cot straps that are on the ambulance cot themselves to assist them in restraining the patient.

Q. You just mentioned soft restraints. Was Mr. Goode restrained with soft restraints?

A. Oh, no, these are anything but soft restraints. These are hand custom chains.

Q. Are soft restraints able to hold agitated patients, in your experience?

A. Oh, yes. If they're applied properly.

The restraints are going to hold a very agitated patient very well, even significant sized guys, like myself. I mean, certainly the stature of Mr. Goode would not have tore them off.

Q. Have you ever had patients in your own experience that you've restrained using the soft restraints? You've done that in the past, right?

A. Yes.

Q. Have you ever done that on a patient much larger than Mr. Goode?

A. Oh, yes.

Q. Have you ever done it on a patient who is agitated?

A. That's really one of the reasons we do it, yes, absolutely.

Q. How about patients who are on heavy stimulant drugs like cocaine or methamphetamines?

A. We aren't able to discern right at that moment unless somebody tells us what the drug is, but patients who are acting in the same or similar circumstances as Mr. Goode are retained in that four-point position, which is on their back and their limbs individually restrained, yes.

Q. Have you ever seen, in those patients

who are agitated, have you ever seen the four-point restraints fail when they were properly applied?

A. Never.

Q. You made reference to the ACLS protocol and we've made it an exhibit here, but we haven't talked about it much today. Does the ACLS protocol inform the care that an EMS, that a paramedic or other EMS personnel are supposed to give to a patient?

A. Yes. The American Heart Association promulgated this document, it's the Advanced Cardiac Vascular Life Support Provider Manual. This manual addresses cardiology problems both for pre-hospital, hospital physicians, nurses, this is the document that educates the pre-hospital, the care of individuals.

Q. Did Ms. Graham comply with this ACLS protocol?

A. No.

Q. In her treatment of Mr. Goode?

A. No, sir.

Q. Explain that to us. What did she do wrong?

A. Well, what we have, I mean, she, Ms.

Graham, identified SVT. And you do not need a 12-lead to have a differential diagnosis of SVT.

Now, in this textbook, SVT in a patient is broken into two particular sections; a stable patient which could be me, as I sit here in front of you now with an accelerated heart rate, but I'm still talking, my blood pressure is still reasonable, I mean, those are stable patients.

Then there are unstable patients, and the unstable patients are a great example of what Mr. Goode is. I mean, if you look at the signs and symptoms of an unstable patient, you can see right here, acutely altered mental status. Now, we know he has a heart rate greater than 150 beats per minute, and at one point it gets all the way up to 180.

So these guys, "these", I say these guys as a patient group, these are profoundly unstable patients, and they need to be cardioverted. We need to stop that heart rate. In this case there were a couple of things that could be done. You could have given him a death card, or you could have actually used synchronized cardioversion. But you've got to bring that heart rate down because it's very clear

that the longer they go at this rate, the more sick they become. They become acidotic, they become hypoxic, that heart rate is clicking along so fast that the brain isn't being perfused well, the kidneys aren't being perfused well. There's a lot of serious medical problems that can develop from sustained SVT.

Q. You mentioned in your response to that question that you don't need a 12-lead in order to perform a differential diagnosis. With the rhythm strip and the information that Ms. Graham had, did she have enough information to begin treating Mr. Goode for his accelerated heart rate?

A. Well, absolutely. And, in fact, she even documents that. She writes in her patient care chart, SVT. And then when you start piecing the rest of the puzzle together, that he's profoundly agitated, he's not communicating, he's altered mental status, he's thrashing and fighting about, you start putting that all together, you can start seeing you have a profoundly unstable patient in front of you.

Q. You mentioned the pulse oximeter, and you also mentioned that the I.V. was part of the

treatment that Ms. Graham was able to give. Do you have any opinions about whether or not Mr. Goode's oxygen levels should have been monitored with pulse oximetry in the ambulance?

A. Absolutely, they should have been monitored. I mean, his agitated state, if you go through the protocols that we identified, I mean, pulse oximetry is in all of them. I mean, we need to know what this gentleman's oxygenation saturation levels are because it can give us insight as to what's going on with him.

I mean, for example, agitated patients may be profoundly hypoxic, and separate of any drug ingestion. So you could have an agitated patient who you find them to be uncooperative and moveable, they're hypoxic, give them some oxygen. You will see a change in their mental status.

Q. You mentioned briefly that Ms. Graham said she couldn't get the pulse oximeter to stay on because Mr. Goode was moving around too much.

If she was unable to, well, first of all, do you have any opinions on whether or not her failure to do pulse oximetry was a violation of the standard of care?

A. Well, it is. The failure to use pulse oximetry is, because the protocols tell you to do it. Now he's agitated, so it's going to be a little more difficult to do that. I mean, we're talking about something that clips on a finger. I mean, it's not, if I'm flailing around, it's going to be hard potentially to get that. So how do you resolve that. Well, you knock them down. You give them medication to get them out of his agitated state, and then you can start monitoring his pulse oximetry.

Q. Assuming that Ms. Graham is unable to get pulse oximetry, even after putting in an I.V., even with the assistance of police officers, if she was unable to get the pulse oximetry on, is there anything she could have done to make sure that Mr. Goode was not going hypoxic?

A. Oh, yes. And separate of even having that number, you give the patient oxygen. I mean, because you can't overdose someone on oxygen. I mean, in this condition. We're not talking about a COPD, we're not talking about some of those other cases. Give him oxygen. If you don't know, just give him oxygen. I've never had a patient who has

arrested because they had a pulse oximetry of 100 percent. If you don't know, give it to him.

Q. The multiple standard operating procedures that you cite in your report mention giving oxygen. Is it a violation of each of those operating procedures to fail to give oxygen in this case?

A. It's the cumulative effect. That's why I looked at the individual protocols, and they all state, give him oxygen, give him oxygen. So these were all opportunities to provide Mr. Goode oxygenation which, she didn't do it.

Q. Now, one of the things that you've mentioned a few times is that Mr. Goode should have been turned on his side for transport, and I believe you provided some diagrams of how that's done in an EMS setting. Have we made that an exhibit to this deposition?

A. Yeah. I'm holding -- well, the one I have here isn't referenced, I gave counsel the one with the textbook cover and the year of publication. But this one is Figure 53 of the textbook, it's the, I gave it to counsel, it's a depiction of four ways of positioning a patient on an ambulance cot.

Q. Are those, all of those safe and secure ways to transport a patient?

A. Absolutely, yes. These are all safe and appropriate ways to transport a patient.

Q. Have you ever used those yourself?

A. Every single one of them.

Q. When you have an agitated patient, are you able to turn the patient on their side?

A. Yes. And, in fact, Picture B, Picture B shows how you want to get a patient on their side. Now, EMS isn't easy, I mean, if it was, everybody would do it. But my point here is even with the agitation that Mr. Goode exhibited even early on, getting him on his side is the most critical thing, we need to be able to make sure he's being ventilated. And having him face down and prone does not facilitate that at all.

And so you can either have him facing you or facing the other way.

MR. DILLARD: For the record, that would be part of Exhibit 7.

A. Yes, sir. Get him on his side, get him on his side. That is of the utmost importance.

Q. In your experience in dealing with

agitated patients, have you ever had the police assist you in positioning a patient or restraining a patient?

A. Well, in my experience, in 36 years, the police officers have always, I've never, never run into a police officer who said, no, I'm not going to turn him on his side. I have had police officers help me reposition patients. I have had police officers in the ambulance with us. Anytime that I have needed the police officers to help me do something, they have always been forthcoming in assistance. I've never seen one say, no.

Q. You talked a little bit about the hand-off between EMS and a hospital. Have you ever seen a hospital, when a patient is transferred to them, leave that patient in a prone, hog-tied position?

A. Absolutely not. And I can speak to this, because I've been in the emergency departments, I've delivered them patients, none of mine have been up that way, but, I mean, they wouldn't allow it. They just simply would not allow it.

My experience in major hospitals within

the city has been, even if they've been brought in in a hog-tied position, the physicians and nurses get them out of that thing as quickly as they can and will restrain them on their backs. I've never seen a hospital not pay attention to that.

Q. I want to talk a little bit about what Ms. Graham did when she came up on the scene. Now, Mr. Goode was already in restraints when Ms. Graham arrived?

A. Yes, sir.

Q. What was she required to do when she came upon a hog-tied, prone patient who needs to be transported to the hospital? What was she required to do there to meet the standard of care?

A. Well, it's quite simple and I suggested this earlier. All she had to do was rotate him 90 degrees. I mean, it's not highly technical, she didn't need any special equipment. All she had to do was say, guys, get him on his side. That's the first and foremost thing, if she would have just got him on his side. And then once he was placed on the ambulance cot, maintained in that position. She didn't even have to touch the patient really, she could have asked the police officers to help her.

But it's, all she would have had to do was rotate him.

Q. Is that opinion to a reasonable degree of medical certainty as a paramedic?

A. Absolutely. I mean, it's even contained within the protocols and all of the texts that I identified in our discussion today.

Q. Have you ever administered chemical restraints to an agitated patient?

A. Yes, sir, I have. The biggest issue now, and I'll tell you, I face it with some regularity, is bath salts. Bath salts and their ingestion produces extremely aggressive and violent patients. It would have been quite comical to be a spectator a few months ago when I'm literally wrestling around an intersection with a gentleman who was later found to be on bath salts. We had to give him ketamine to help control him because he was truly in a very critical condition.

Q. Once you give those chemical restraints, what follow-up care do you have to do? Do you have to continue your care after you give those chemical restraints?

A. Well, it's very definitive. Once you

give chemical restraints, you have to monitor those patients in the back of the ambulance. You have to make sure they have a respiratory rate, that their heart rate stays up, that they're ventilating well, and ventilation is different from respiration. Respiration is a numerical value. Ventilation is the actual exchange of gas in the chest cavity and that can be determined by the patient's status, and SpO2 is one of them.

Q. You had mentioned earlier that altered mental status can be caused by a number of things, you've mentioned low blood sugar, you've also mentioned hypoxia. When you have a patient with altered mental status, do you ever just assume what's causing that?

A. Well, if you're smart, in medicine, you never assume anything. I mean, we know that there could be an entire variety of things causing altered mental status. So that's why the protocols that I work under, that are in Mississippi as well, clearly tell you to start, here's how we assess that out. Here's how we put together pieces of a puzzle. And those pieces of a puzzle are what show us what's wrong with the patient. So glucose is important.

Q. Now, is it possible to have more than one thing causing an altered mental status?

A. Certainly. It's absolutely possible that this guy has a diabetic condition, but he's also a drug user. So, I mean, there are potentially multiple things that can cause that.

So when you have a patient who has a low blood sugar, what can you do, you give him some D50. You're not going to hurt him. So if it fixes the problem, well, then, it's a glucose issue; if it doesn't, then move on. There are two medications that you can give to almost every patient and not hurt them. Three. Narcan, which is if they have a narcotic on board, will help to fix that; glucose, which, if they're hypoglycemic, will fix that, and oxygen. Any three of them, you can give those three to you and I sitting here, it's not going to kill us.

Q. You were asked very early on how many patients you've cared for in the past year.

Over the span of your career, do you have an estimate, I know you won't have an exact number, but do you have an estimate of how many patients you have personally cared for in an EMS

setting?

A. I can give you parameters. Let me just say, the city of Toledo, this district responds to some 65,000 calls for service a year, somewhere in there, 60s, mid 50s. I work every third day. Certainly the number is in the thousands. I don't have a top number, I can't say a hundred thousand. I don't know. But certainly thousands.

Q. How common is it for, in those thousands of patients, how common is it for you to experience an agitated patient?

A. It's rare. I mean, it's not a daily occurrence. But it's certainly, the agitation could be related to a lot of different things, but it's several times a month, I'll bet.

Q. Have you ever transported a patient hog-tied?

A. Never. And when I have arrived, and a case which jumps out at me is when a police officer did have someone in a hog-tied position, face down, and as I was walking toward the patient, I was already chirping to the police officers, let's get him on his side, let's get him on his side. I don't care why you've got him, that's not my business, but

my business is to make sure that this guy can be ventilated. I got him on his side. Even at times before I was putting my hands on the patient, guys, we've got to get him on his side.

Q. Why do you want to get him on his side?

A. Well, it goes back to what we've been talking about, and the fact when he's on his chest in that position, or she's on her chest in that position, they have a limited ability to have adequate ventilation. It truly compresses their ability to be well-ventilated. I don't care why they're in your custody, officer, but I need to get this patient on his side so he can be properly ventilated.

That's the reason why, because we know that with time, being on their chest and highly agitated, they're going to arrest.

Q. While Troy Goode was hog-tied and prone in the ambulance during Ms. Graham's care of him, was his condition improving or was it deteriorating?

A. He was deteriorating.

Q. How do you know that?

A. Well, I know that by, let's just look at a couple of different things that are on the record

reflected by Ms. Graham. The biggest thing that you've got to look at right here is the pulse rate. What's happening with his pulse rate? The pulse rate is continuing to rise, she has a 156 number, then it goes to 164, now it's at 186. That heart rate is non-sustainable.

And if you couple in the heart rate along with his position and the other circumstances that you have as an awareness of what's going on shows that he is deteriorating.

And, lastly, the fact that he has a pulse oximetry upon arrival at 90 percent, you don't get that way in 30 seconds. You get that way over time.

Q. Now, you mentioned one of the reasons that you doubt Ms. Graham saying that she felt very threatened is because she was able to get an I.V. into Mr. Goode's arm. How hard is it to get an I.V. into an agitated patient?

A. Well, I speak from experience. If a patient is thrashing and rushing and fighting you, inserting an I.V. is a rather technical thing. I mean, you've got a little vein and you've got this needle that you have to thread into that little

vein, it requires, if you've ever given blood or had a blood test done, you realize there has to be some skill involved. I mean, just think of yourselves, if you've ever given blood or had a blood test, you start thrashing around, the probability of that phlebotomist hitting the target greatly diminishes. So you hold still.

So even as a practitioner, me sticking those needles in, I've had to have patients' arms held in place so I can get the needle into the vein and slide the catheter in and then secure it. So it takes a little bit to do. It's not like a dart that you just kind of pitch at and it goes in.

So if she was able to do that, it tells me that he's within an area that she can operate, that she's able to do that, then she should be able to do other things.

Q. I'm going to give you a hypothetical here. Hypothetically, assume that you have a patient who has the same vital readings that Mr. Goode had upon admission to the Baptist ER. Assume that that patient has a red face, has their mouth open and looks as though they are trying to get a breath and says the word, breathe. Would those be

signs to you, as a paramedic, that this person is in respiratory distress?

MR. DILLARD: Object to the form of the question.

MR. McINTOSH: Join the objection.

MR. MACAW: Join the objection.

MS. WADDELL: Join.

MR. DILLARD: You can answer.

A. Well, let's take him out of the emergency department, put him in his room with us. If he exhibited all of those signs, he exhibited those signs, he absolutely has respiratory distress.

Q. Let me ask the question more broadly. Can you tell us what are some common signs of respiratory distress that you have to look for as a medical care provider?

A. Well, respiratory distress, you know, when I -- counsel, I'll use you, if you don't mind. If I was assessing counsel sitting next to me here, I would look at his respiratory rate and quality, how well is he breathing, what's his pulse oximetry, what is his skin color, is he able to communicate with me in sentences. We go right back to the thing of, you know, just because a patient says, breath, I

mean, that doesn't mean that he's adequately breathing. You know, there are dying patients I've had that, you know, are saying, help, you know, that they're not breathing well. So you want to look at a number of those things. What is the skin color, what is his respiratory rate and quality, what is his mental status, is he alert, is he communicating, is he dealing with me well one-on-one, is he speaking in full sentences, what is his heart rate, what is his pulse oximetry.

So those are the things that draw that picture for me and give me an idea of someone's respiratory status.

Q. What sort of skin color changes are common in people who are having respiratory issues?

A. Well, what you'll see many times are cyanotic patients, but, that caveat is held out that patients who are agitated or have been in fights who are aggressive, it would not surprise me to have a red face because all of that profusion is going on as well. So it wouldn't surprise me if they had a red face.

Q. All right. Mr. Krause, based on your review of materials in this case, are you familiar

with the Mississippi standard of care for a paramedic?

A. Yes.

Q. Did Ms. Graham violate that standard of care?

A. Yes. In her own admission, she admitted she did it.

Q. Is that an opinion you hold to a reasonable degree of medical certainty?

A. Absolutely.

Q. Did that violation of the standard of care cause a deterioration in Mr. Goode's medical condition?

A. Yes.

MR. DILLARD: I'm going to object to the form in that it calls for causation from medical testimony.

Q. Based on your review of the medical records, did it cause a deterioration in Mr. Goode's medical condition?

MR. DILLARD: Same objection.

A. Yes.

Q. Is that an opinion that you hold to a reasonable degree of medical certainty?

A. Yes.

MR. McCORMACK: I think that's all I've got for you. Thank you, Mr. Krause.

THE WITNESS: Yes, sir.

MR. McCORMACK: I'll hand you back over to Brad who I think has a few more questions for you.

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RE-EXAMINATION

BY MR. DILLARD:

Q. Just a couple more, sir. Looking through the material that you brought with you today, I did notice some handwritten notes here.

A. Yes, sir.

Q. What are these notes?

A. Those are, I didn't have the physical copy of the deposition, I was reading it electronically, and these were notes which prodded my thought process.

Q. Could we take a look at those?

A. Absolutely.

Q. So these would be several pages of just handwritten notes where you went through individuals' depositions or through the file and

made notes of matters you deemed significant?

A. Yes, sir.

Q. Okay. I'd like to attach a copy as an exhibit, the next exhibit to your deposition. We can mark that, have a copy made when we conclude.

A. Yes, sir.

Q. Are there other materials here other than things that we have made exhibits, such as this current DOT National Standard curriculum? Is this something you intend to rely on?

A. Well, I think it speaks to one of the issues here in, and I don't know if this is 5 or 10, this exhibit, but in this exhibit, there's a phrase that says contrary to the methods recommended in the U.S. DOT curriculum, EMTs and para -- should not be transported. In the early '90s when this curriculum was being written, it's well over 20-some years now, there was a reference in a DOT curriculum about transporting a patient in a prone position. That was before a lot of the research had come out, and a lot of the edifications came out. And there was a sense to add to, suggest that maybe that was appropriate.

Well, it's clearly been debunked in the

last 20-plus years, and this particular document specifically addresses those two questions.

Q. Okay. I'm going to make some of these additional documents another exhibit. So we'll include the DOT --

A. Sure.

Q. We have a letter, July 3, 2017 letter from Mr. Edwards' office that encloses various material.

A. Yes, sir.

Q. We'll make that part of that same exhibit. We have a document marked Roman numeral V, Restraints at the top. What is that?

A. Well, I'm not being a wise guy, sir, it's V because there's a series of protocols, this is Lucas County protocol, and this Lucas County protocol is what we operate under.

And so I wanted to draw, you know, as I'm sitting in my office, if I'm going to be critical of the State of Mississippi, what am I doing, because I'd look like a jerk if Lucas County said, yeah, put him on his face all the time. Well, it shows consistency, in my opinion, and says here very clearly, in number 3, this is the Lucas County

protocol under which we function, and I have functioned within the last several years.

Number 3, restrain the patient in a lateral or supine position. No devices such as backboards, splints or other devices will be on top of the patient. The patient will never be restrained in a prone position, the "never" is in bold type. So this just shows consistency. Hey, we're doing it here in Lucas County, Ohio, that's exactly what Mississippi says they should do as well. It shows consistency.

Q. To make sure we have the same document, that's February 2014 at the bottom?

A. Yes, sir.

Q. We'll make that part of that next exhibit. What other material do you have in here other than the documents we already made exhibits? I noticed some standards, I believe, referred to. Do you mind if I stand up and look with you?

A. No, sir. These are just the protocols themselves, sir, that we were talking about. This is 605, this is pulse oximetry, this is 107, SVT, this is 112, SVT with a pulse. This is another copy of 605. Another copy of 612.

Q. All right. If I can see those. We're going to add those into this group, we're going to make a cumulative exhibit. Then there's a document that looks like an article maybe, Firehouse?

A. These are a series of articles, there's a few of them in here. Transporting violent patients. This one was written in 1996. It talks about not putting a guy or a patient in a prone position and all the reasons why you don't do it.

This is an article written by The Commercial Appeal, it's by Jody Callahan, it's an article written in the newspaper that says cardiac problem cause of death, not hog-tie restraint, says DA. It's just a copy of that article.

Q. This is specifically in regard to Mr. Troy Goode?

A. Yes, sir.

Q. This article?

A. Yes, sir. In fact, the second byline, Troy Goode was behaving erratically, so on and so forth. That's out of the newspaper.

This one is written by a guy out of EMS World, it's How to Deal with Combative Patients. It was from February 3, 2012. He basically talks about

do not restrain the patient in a prone position, do not hog-tie a patient, it goes on to talk about why you don't do that.

This is another article, family of a man who died while restrained on stretcher gets $875,000. The family of a 27-year-old who died from positional asphyxia when secured in a prone position received a settlement from a lawsuit. Five EMTs involved in the incident were suspended. This is out of Millville, New Jersey, it's out of 2015, a similar case such as this.

The last article is also out of a journal, it's called Excited Delirium, and it's a medical emergency, not a willful resistance. In other words, the application here, and this is out of 2015 as well, it's not that Mr. Goode was being a jerk and trying to fight the police, his testimony indicated he had no idea who was there. He's suffering a medical emergency, and it should have been managed that way and it wasn't. That's the series of those.

Q. Are these all articles that you would have found just doing the Internet searches?

A. Yes, sir.

Q. We'll make those part of the next exhibit. And is there anything else we have not already attached as exhibits?

A. No, sir. Unless you didn't include the ACLS manual, but I think you did.

MR. McCORMACK: I believe that's one of the earlier marked exhibits.

A. I tried to send a lot of those over so you had them ahead of time. Yeah, there you go.

Q. That's Exhibit 6?

A. Yes, sir.

Q. Okay. I think we've covered then everything that you've reviewed and otherwise relied upon in reaching your opinions?

A. Yes, sir.

Q. And we've looked then at the content of your file in regard to this matter?

A. Yes, sir.

MR. DILLARD: All right. Thank you, sir. Any other attorneys have any further questions?

MR. McINTOSH: No further questions here.

MS. WADDELL: None here.

MR. MACAW: None here.

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RE-EXAMINATION

BY MR. McCORMACK:

Q. I want to follow up on what you just went through. Mr. Krause, you mentioned that you believe excited delirium is a medical emergency, you were referencing the article there. Is there a way that if you believe in excited delirium, is there a way to treat a patient who has it?

A. Well, absolutely. In fact, you have a protocol that addresses that. Mississippi protocols, if I may, sir, may I have that pile back? Thank you. Your own protocols say that it's an issue and it's 612. It says, hey, if you have this condition or you believe this to be the condition, give the patient oxygen, make sure their airway is open, supportive care is you talking to the patient, trying to calm the patient down, those are the, position, get them in the right position, pulse oximetry, then it goes on to the paramedic care which would be get an I.V. in him, check their blood glucose level, you can titrate more glucose if that's the issue. 12-lead if it's appropriate, and

then volume. So even Mississippi protocols address, if you believe that's the problem, how to manage it.

Q. So assuming that we believe that excited delirium is a real condition and assuming Ms. Graham thought that, did she appropriately treat Mr. Goode for that condition?

A. No, sir.

Q. If a person, if you believe that that is a condition, you believe that a patient has it, should that patient be hog-tied?

A. Absolutely not.

Q. Why not?

A. Well, it all goes back to the very same thing. You get a patient in that restrained position, you get them in the prone position, they're going to stop breathing at some point.

You have to get them off their stomach. You have to get them on their side. I think even one of the articles specifically addresses that. And let me go to it. It's an article on excited delirium and it says, hey, that there's still controversy, is it agitation, what is it, but what does it look like. Then here's what it says. You know, make sure that you don't get this guy on his

back, you know, chemical sedation is needed as quickly as possible to reduce the risk of impending death. So if you were to believe that, I mean, it's very clear, it's also included in their protocols.

But it says chemical sedation is needed as quickly as possible to reduce the risk of impending death. Available medical personnel need to be called to the scene, it's us that were already there, this is what happens. Well, then, here. Here's what it also says. This isn't that far out of the realm. Unfortunately up to 250 people die as a result of excited delirium each year in the United States, an estimated 8 to 14 percent of those with the condition. That's a significant number.

So there's ways to manage it, and your own protocols tell you how to do it, yours being Mississippi.

Q. Is hog-tying part of the protocol for how to treat it?

A. Absolutely not.

Q. That would actually hurt rather than help?

A. Oh, yeah. It's counterproductive.

MR. McCORMACK: Thank you, Mr.

Krause. Nothing further from me.

THE WITNESS: Yes, sir.

MR. DILLARD: Do you want the witness to read and sign?

THE WITNESS: Read and sign.

MR. DILLARD: Very good.

Do you guys want to talk to the court reporter about ordering a copy or what you might like to order?

MS. WADDELL: Yes. This is Amanda Waddell, I need a full and condensed copy, please.

MR. McINTOSH: This is John Martin McIntosh, I want a full, condensed and electronic copy, please.

MR. MACAW: This is Matt Macaw, I'll take the same as John Mark.

MR. GASS: Ric Gass does not need a copy. Thanks.

COURT REPORTER: Would you like a full and a condensed also?

MR. DILLARD: Full and condensed.

COURT REPORTER: And an E-trans?

MR. DILLARD: Yes.

COURT REPORTER: Do you also need anything at this time?

MR. McCORMACK: We'll do the condensed and E-trans.

(Court Reporter marked Exhibit Numbers 11 and 12.)

(Deposition concluded and witness excused at 12:10 p.m.)

(Signature reserved.)

- - -

SIGNATURE PAGE

Date of Deposition: October 11, 2017

Correction page(s) enclosed? Yes____ No___

How many correction pages?____

_____

ROBERT C. KRAUSE, EMT DATE

- - -

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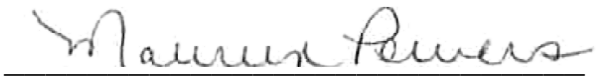
C E R T I F I C A T E

I, MAUREEN POWERS, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given was by me reduced to stenotype in the presence of said witness and afterwards transcribed; that the foregoing is a true and correct transcription of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee of or attorney for any of the parties in this action; that I am not a relative or employee of an attorney of any of the parties in this action; that I am not financially interested in this action, nor am I or the court reporting firm with which I am affiliated under a contract as defined in the applicable civil rule.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio on this 19th day of October, 2017.



MAUREEN POWERS
Notary Public
in and for the State of Ohio

My Commission expires July 23, 2019.

C E R T I F I C A T E

I certify that Robert C. Krause, EMT has been given the allotted time to read and sign the deposition transcript and has failed to do so.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio, on this 20th day of November, 2017.

Maureen Powers

MAUREEN POWERS
Notary Public
In and for the State of Ohio

My Commission expires on July 23, 2019.

- - -